A COMPARATIVE ANALYSIS OF MICHIGAN'S TRANSITION FROM INSTITUTIONAL TO COMMUNITY BASED SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

by

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ABSTRACT

The national trend of shifting from institutionally based services for persons with developmental disabilities towards community based services was studied with emphasis on the period from 1977 to 1986. Michigan's efforts are described in detail and comparatively examined versus the average state program. Michigan demonstrated extensive deviation in the areas of institutional funding, institutional population census, and community funding. During this same period of time there were dramatic fluctuations in the Michigan's economic climate. This paper explores those factors which have substantially contributed to the untypical expenditures and community placement efforts demonstrated in Michigan.

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I. Introduction

State coordinated mental health services for persons with developmental disabilities have undergone substantive changes throughout the country during the past few decades. Michigan has been nationally recognized as a leader with respect to its deinstitutionalization efforts and community service programs since the early 1980's. This research focuses on the transition from institutional to community services throughout the country and examines how Michigan's experience compares with national trends.

Presently, there is limited empirical research which:

(1) Provides a model for the comprehensive examination of the factors affecting a state's deinstitutionalization efforts and what the specific impact of those efforts may be. We may know what a given state's policy is at a particular period of time, but we may not know why it is that way.

(2) Examines a state's service and funding data as a point on a standardized scale to allow for more detailed analysis of that particular items and comparative analysis between items. Related quantitative data often provide enough information

for us to compare our state with the entire country or rank our state in comparison to others, but little information is available to examine where one state lies in the entire distribution of all individual state efforts.

(3) Provides this information on a state by state basis. The complexities involved with managing this many diverse factors is difficult. A comprehensive examination of each individual state throughout an extended period of time is complicated further by the continued evolution of state specific variables. The end result is that far too often we analyze different state programs solely in relation to one another (perhaps as a share of the state budget pie) rather than in comparison to other similar programs throughout the country.

This paper focuses on addressing each of these problems as they relate to the examination and comparative analysis of Michigan's program.

Synopsis of Intent of this Research

This research examines the funding of Michigan's state coordinated institutional and community based services for

persons with developmental disabilities (DD) for fiscal years 1977 through 1986.

Historical factors and empirical studies are reviewed to provide specific background information concerning relevant explanatory factors which effect state mental health services and funding. A set of assumptions about Michigan's funding and service level was then provided which is consistent with prior research and stated trends. A detailed quantitative analysis is then provided for Michigan's funding and service levels especially as they compare to national averages and distributions. Michigan's actual position will then be utilized to confirm or reject the stated assumptions. The emphasis is on revealing the budgetary and qualitative implications of Michigan's mental health polices. Finally, those manipulable factors which may lead to improved finances and services are addressed.

Limitations

Those limitations which must be clearly delineated include:

(1) The extensive reliance upon secondary research data from which a large data base was reproduced (especially Braddock, et al, 9/86).

(2) Inherent problems with pairing time related

information collected from the same fiscal year but having different beginning and ending months (i.e. U.S. census statistics and state budget data).

(3) Budget data categories may vary significantly over time solely due to changes in state accounting procedures.

(4) This study is time specific and the present environment may not be accurately portrayed by these results.

The costs and time associated with conducting research without these limitations are beyond the scope of this study.

This paper should be of interest to advocates, program administrators, policy makers, service providers, educators and other persons generally concerned with services for this population.

II. Historical Background

State institutions have been utilized in Michigan since the latter 1800's to provide residential services for persons with developmental disabilities. Prior to this time families were completely responsible for independently serving these individuals at home, which usually meant on a rural farm. Specialized services were virtually non-existent, however this population was fully integrated with respect to their location of residence.

As society began to identify and label these people, primarily according to their IQ level, the number of persons needing services rapidly increased.

A medical model was widely utilized during this period, as the treatment mode designed to serve them. They were often sent off to segregated institutions to be treated and cured before returning to their communities. Even though these centralized facilities often provided the only professional treatment available, the concept of curing them in abnormal institutional environments was inept, due to the nature of their impairments.

As larger numbers of persons were labeled, additional states built institutions, and gradually increased state financing to provide for and maintain these services. In

1967, the institutional population peaked at 194,650 and then began declining to approximately half that amount during the following 20 years.[1,2]

In Michigan the institutional population also reached its peak in 1967 with 12,697 persons living in institutions for the developmentally disabled.[3] This level has also dropped significantly to 1505 persons in FY 1986 and further to an estimated 1100 persons by the end of FY 1989.[4] Michigan depopulated 88% of its persons residing in institutions from 1967 to 1986 while the total national rate of decrease was only 52% during the same period. This will be analyzed more completely later in this paper.

This national and state decline was influenced by a multitude of factors including though not limited to:

Changes in Terminology
Public Awareness
Advocacy
Litigation
Public Funding

The impact of each of these changes are discussed more completely herein.

Changes in Terminology

The vast majority of persons residing in institutions for the developmentally disabled prior to 1967 were considered to be mentally retarded to some degree. There were changes in the definition of mental retardation in the 1960's and another change in the 1970's which reflected diverse opinions on how these persons would be served. The first had a very broad definition while the latter was much more restrictive.

In 1961 the American Association on Mental Deficiency - AAMD, (now called the American Association on Mental Retardation), revised their definition to classify persons whose IQ was at least one standard deviation below the mean, as being mentally retarded. One article relayed the impact of this change, "overnight, the prevalence of retardation jumped from around 2% to 16% of the population increasing the ranks of retarded persons in our nation from approximately 6 to 32 million."[5] This change enabled persons who had IQ scores between 70 and 85 to be classified as borderline mentally retarded and therefore receive residential services. Society's perspective at that time was clearly supporting the model of segregated services for the developmentally disabled as demonstrated by this broad classification.

Later it was discovered that most persons in this

borderline group were quite capable of living independently and only performed below average in academic settings. In response to this realization in 1973 the AAMD made a subsequent revision in its definition which now stated:

> Mental retardation refers to significantly subaverage intelligence existing concurrently with deficits in adaptive behavior and manifested during the developmental period.[6]

The term "significantly" refers to at least two standard deviations (as opposed the the 1961 AAMD definition of just one) below the mean. The result was that the entire classification of borderline mentally retarded was eliminated. Furthermore the requirement that this deficit occur concurrently with deficits in adaptive behaviors eliminates labeling all those persons who score poorly on the IQ test but can otherwise function independently. Clearly the focus of this latter definition was more on independence and integration rather than segregation.

Public Awareness

The living conditions in institutions during their population peak were abominable. One photographer for the Chicago Sun -Times, Jack Dykinga, won the Pulitzer Prize for

his 1971 photographs of Dixon and Lincoln state institutions for the retarded. He made the following comments about his experiences," For the first hour and a half, I didn't take any pictures at all. I just watched... sort of overcome by the horror. Just the sheer terror of the whole thing... It was a real shock to my senses... like nothing I had ever seen before. Warehouse people - many of them naked, with excrement smeared on their bodies. All kinds of weird sounds.. horrible smells. It was just a total sensory confrontation."[7] The pictures were described as follows:

> Inside the crowded day rooms of these mammoth institutions, euphemistically called schools, thousands of retarded children and adults- societies discards-live an existence of utter degradation, loneliness, and despair. Hopelessness has worn away any remnant of pride and motivation. In these depersonalized warehouses, they are herded around like animals... robbed of any chance to progress and grow. The wandering specters, sedated with drugs, quietly languish away. The more aggressive ones are tied to chairs until staff can attend to them.[8]

This was just the tip of the iceberg regarding the publicity which was to follow. This exposure had been successful in thwarting a proposed decrease in the Illinois mental health budget. Similar news stories appeared during the 1970's in

other states about their own institutions, including an expose about conditions at the Plymouth Center in Michigan. Usually the disclosure was accompanied with legal action by advocates.

In addition to the environmental atrocities which were noted in the early 70's, research also demonstrated greater developmental progress and benefits by persons living in community versus institutional settings. Haney recently reviewed the research of deinstitutionalization for pre and post 1970 periods and summarized the empirical support for community placements as follows:

> The research literature provides support (albeit methodologically weak support) for both initial deinstitutionalization efforts and continued depopulation of the present day institutions. Little research addresses questions about enrichment and the applicability of positive effects for those of all ages and at all levels of retardation. Concerns about the comparative benefits of community versus institutional placement for those with more severe mental retardation are becoming more important as those with milder mental retardation are more frequently in community placements already...The absence of more carefully controlled research is disappointing. Decisions are being made about lifetime placements, and accurate information on the consequences

> of these decisions should be a vital part of the decision-making process.
>
> Although in the final analysis, decisions will flow from questions based on values (e.g.,"Is the effect of placement on adaptive behavior important?", "Is life-style satisfaction important?"), scientifically derived answers to questions about valued outcomes may serve to guide the decision making process.[9]

The complexities with conducting comparative studies of different people, living in dissimilar settings, with diverse services, and costs has indeed made research difficult. In October of 1987 Knoll, et al., presented a paper at the TASH National Conference, entitled, "For what it's worth: on Reading Research on Economics of Community-Based Services." The authors discussed the complexities with comparing institutional and community services and made this comment on this issue of values and research:

> Another fallacy buried in all research which has relevance to public policy decisions is the myth of value free science. Every researcher working in the behavioral sciences or human services has a personal perspective on the issues he or she is examining. To say that this personal belief system or individual ideology does not influence research and the

> presentation of finding is unrealistic... It should be recognized as such. At least by stating individual biases openly and honestly the reader all the information necessary to critically evaluate the information presented. [10]

The writers went on to say that their review of the literature was based upon their firm preference for community versus institutional services.

Public awareness has changed dramatically in the past 25 years with respect to community based service needs of these persons. This change appears to have been prompted primarily by abhorrent institutional conditions in the 1970's. Related research and value based factors have also had their impact on recent changes in the publics perception and opinions. Attitudes have shifted the service preference from segregated to integrated settings.

Advocacy

The most widely recognized advocate group for this population, the Association for Retarded Citizens (ARC), was not politically organized nationally until the early 1970's. It wasn't until 1969 that they established an office in Washington, D.C.. [11]

However the numbers of politically active advocate groups expanded dramatically throughout the 70's and 80's some of the more notable additional groups now include:

Association for Persons with Severe Handicaps
American Association on University Affiliated Programs for Persons with Developmental Disabilities
Center on Human Policy
National Association of Development Disabilities
National Down Syndrome Congress
National Association of Private Residential Facilities
People First
United Cerebral Palsy

A more complete listing noted in a recent advocate publication is included in Appendix A.[12]

Many of these groups have developed policies on de-institutionalization which refute the maintenance of segregated settings; however few are as extensive as this excerpt of a 1987 policy by the Association for Persons with Severe Handicaps an organization which:

> ... believes that a mutual consideration for both quality services and quality life are necessary and that this mutual consideration cannot be achieve in environments which segregate persons with disabilities

from the community. Thus, TASH calls for the termination of services, activities, and environments which :

(a) remove children from their homes and neighborhoods, and citizens from their home communities;

(b) require that persons with disabilities live under circumstances that would not be considered acceptable for persons within that same age range were they not disabled, including large scale group homes and ICF/MR's (Intermediate Care Facilities for the Mentally Retarded).

(c) rely exclusively upon paid caregiver and other professionalized relationships to the detriment of more normalized social support networks, family systems, peer relationships, and friendships; and:

(d) stigmatize persons with disabilities by portraying them as individuals in need of help, care, and sympathy rather than dignity, respect, mutual companionship, and enjoyment.[13]

This version is far more extensive and radical than prior TASH statements but it probably also reflects their most progressive stand.

The ARC, on the other hand, is historically the only advocate group whose membership includes a substantial portion of parents and family members of persons with developmental disabilities. Their endeavors with litigation and political lobbying have widely championed the cause of state institutional depopulation and improved funding for community based services.

In Michigan the ARC had become an active political force very early. With the appointment of Harvey Zuckerburg in the late 60's, the organizations upcoming priorities were clearly established by their board; (1) Get public education for all children, (2) Get people out of institutions. Mr Zuckerberg was effective with accomplishing both of these tasks before leaving the position two years ago. [14]

The state and national development and expansion of advocacy groups provided the impetus for creating many of the changes which led to societies enlightened awareness of the needs of this population.

Litigation

There have been two types of litigation associated with deinstitutionalization which have been battled during the past 20 years. This includes; (1) Class actions suits geared at forcing the improvement of conditions at institutions or closure of those settings and (2) Neighborhood opposition attempting to deter the development of community group homes for persons with disabilities.

1. Class Action Suits

Advocate groups have utilized the federal courts since the early 1970's to force states to improve the conditions in institutions or actually close them down. A class action suit is filed in District Court and all persons living in that particular setting are identified as class members. The court may issue an order based upon its findings or the issue may be resolved mutually by the parties with a consent decree.

In 1972, the Pennsylvania Association for Retarded Citizens (PARC) brought such a lawsuit against an institution called Pennhurst. A TASH newsletter described the case as follows:

...Opened 70 years ago and "devoted to the segregation

of (retarded) persons," Pennhurst carries a long tradition of abuse. The maltreatment came to the attention of the nation when, in 1973, PARC, persuaded the FBI and the Civil Rights Division of the U.S. Department of Justice to investigate possible civil rights violations. Residents, it was found suffered from "cruel and unusual punishment" in the form of little or no education, over-medication, general neglect and physical abuse. In 1975 PARC and the United States jointly brought a suit against the State of Pennsylvania to force the closure of Pennhurst and placement of the residents into community living arrangements. [15]

Numerous cases have addressed the issue of deinstitutionalization through the courts, in Michigan a case similar to Pennhurst, was filed in 1979 against the Plymouth Center for Human Development, in Plymouth, Michigan by the Michigan Association for Retarded Citizens. This action led to a consent decree to force the closure of this segregated setting.[16] Unlike the Pennhurst case, which was appealed by the State of Pennsylvania over a period of years and finally decided by the U.S. Supreme Court - 451 U.S. 1 (1981), the Plymouth decree produced greater cooperative efforts among the parties.

There were some unique characteristics of the Plymouth

process. Specifically, the ARC- Michigan Chapter had become well established as an effective advocacy group at the time and served as the plaintiff in this suit. In fact, Governor Miliken had authorized them to provide the state's protection and advocacy services. Furthermore, in addition to securing testimony from the parents, the ARC was effective in producing testimony from the resident's school teachers. This provided another objective source of documentation of the Plymouth problems.[17]

Besides producing extensive depopulation of the Plymouth institution, the ARC was effective in negotiating for greater assurances that community services would be provided for all persons leaving the institutions, which included day programs. This issue was a problem frequently cited by parents.[18]

Even with later improvements in institutional settings advocates have continued to propose and defend a right to community placement with more than 20 major court orders or consent decrees being initiated since the early 1970's.[19]

The impact of this type of litigation must be examined from the perspective of who, what, where, when and how:

(1) Who was included in the class? Was it those people living in one small institution in the state or were many

people living in several large institutions specified?

(2) What are the goals of the plaintiffs? Do they seek to upgrade the institution, improve the institutional services, create some community alternatives or close the institution completely?

(3) Where did it happen? Was the state already making advances in improved services or were they completely unaware of appalling conditions.

(4) When was the lawsuit filed? Was it at a time when there was or was not national support for the types of changes sought?

(5) How did the litigation come about? Was it one parent seeking some minimal changes for their son/daughter or was it a unified effort by many people seeking extensive changes with media coverage of the step by step action.

With so many variables it's difficult to identify any historical trends other than the dates the cases were decided which are note on the following table:

Table of Court Orders/ Decrees [20]

Decision/ Last Appeal	State	Litigants	Resolution
1973	NB	(Horacek v. Exon)	Court Order
1973-74	AL	(Wyatt v. Stickney)	Court Order
1973-74	AL	(Wyatt v. Stickey)	Court Order
1974-77	MN	(Welch v. Likens)	Court Order
1975-84	NY	(New York-ARC v. Carey)	Decree
1976	LA	(Gary v. Louisiana)	Court Order
1976-85	PA	(Halderman v. Pennhurst)	Court Order
1978-83	DC	(Evans v. Washington, Barry)	Decree
1979	MI	(Michigan-ARC v. Smith)	Decree
1980	WV	(Medley v.Ginsberg)	Court Order
1980	VT	(In re Robert Brace)	Decree
1980-83	KY	(KY- ARC v.Conn)	Court Order
1981	ME	(Wuori v. Concannon)	Decree
1981	NH	(Garrity v. Gallen)	Court Order
1982	RI	(Iasimore v. Garrahy)	Decree
1982-83	ND	(ARC of N.Dakota v. Olson)	Court Order
1983	CT	(CT-ARC v. Mansfield School)	Decree
1983	TX	(Lelsz b. Kavanagh)	Decree
1985	FL	(Florida-ARC v.Graham)	Decree
1987	OK	(Homeward Bound v. Hissom)	Court Order

A cursory review of this list shows that most of the litigation occurred during the early 1980's. In the past

four years there has only been 1 additional case. However the 1987 Hissom Court Order has been proclaimed to be the most comprehensive order to date. The order mandates closure of the 450 bed institution and placement into very small community settings consisting of 6 or fewer persons.[21] Perhaps both plaintiffs and defendants have become more skilled at presenting their positions with time. Some of the state mental health directors may have utilized this process to encourage their legislatures to upgrade their mental health budgets.

There also appear to be more decrees than court orders during the past 10 years and fewer appeals than there were during the 1970's. Generally the parties appear to be negotiating more and litigating less. A more detailed analysis of this entire phenomenon is discussed under Section III- Literature Review of this paper.

2. Neighborhood Opposition

There have been numerous cases related to local opposition to the development of group homes in their neighborhoods. Usually these groups cite local zoning ordinances which restrict the use of the property to single "family" units. The term family has been accepted in some state court cases (Little Neck Community Association v. Working Organization for Retarded Children, NY, 1976 and

Oliver v. Zoning Commission of Town of Chester, CT,1974)with respect to this population and rejected in others (Carrol v. Washington Township, OH,1974).[22]

Another state issue was decided by the Ohio Supreme Court in 1980. The Court had to consider whether the state law providing for community group homes superseded the Ohio Constitution which granted the power for local zoning laws to municipalities, except when they are not in conflict with general laws. The Court decided against the group home striking down the state law.[23]

The Michigan courts have also been very busy during the last decade. Most of the issues litigated involve challenges to the 1976 zoning amendments - PA 394-398 which states:

> ..In order to implement the policy of this state that persons in need of community residential care shall not be excluded by zoning from the benefits of normal residential surroundings, a state licensed facility providing supervision or care, or both to six or less persons shall be considered a residential use of property for the purposes of zoning and a permitted use in all residential zones, including those zoned for single family dwelling, and shall not be subject to a special use or conditional use permit or procedure different from those required for other dwellings of

similar density in the same zone.[24]

The law was tailored to those homes serving six or fewer persons which was the primary focus of Michigan's deinstitutionalization efforts from 1977 thru 1988.

Numerous court challenges were heard by the Michigan Appeals Courts including cases involving homes in:

Oakland Co.

(1978 -Bellarmine vs. Residential Systems Co.)

Macomb Co.

(1980 -Surrounding Neighbors vs.Community Care, Inc.)

Washtenaw Co.

(1981 -Leland Acres Home Owners Association, Inc., R.T Partnership and Pyramid Human Services, Inc.)[25]

Each of the decisions supported the group home service providers. In the Spring of 1984, and after several additional court decisions, the Michigan Supreme Court agreed to hear the case of The City of Livonia vs. Department of Social Services. On November 21, 1985, the court rejected 12 different issues raised by the plaintiffs and held that the small 6 bed group home for mentally ill or developmentally disabled adults would remain exempt from the local zoning ordinances.[26]

Marion Bates, from the Wisconsin Council on Developmental Disabilities, reviewed the zoning laws and legal challenges throughout the country in her 1987 paper entitled,"State Zoning Legislation: a Purview." She found that unlike the Ohio court decisions,"In Michigan..courts have ruled that a state policy favoring group homes overrides a conflicting restrictive covenant."[27] Montana was the only other state where this was also found to be true.[28]

The period from 1977 to 1987 showed a massive increase in state legislation to pass zoning statutes. According to Bates there were thirty nine states and the District of Columbia who had state zoning laws as of October, 1987, their development occurred as follows:

Table of Zoning Law Changes[29]

Before 1977-

California, Colorado, Minnesota, Montana, New Jersey

1977 -Michigan, New Mexico, Ohio, Rhode Island, Virginia

1978 -Arizona, Maryland, New York, South Carolina, Tennessee, Vermont, Wisconsin, (NJ strengthened)

1979 -Connecticut, Idaho

1980 -Delaware, Florida, Indiana, Nebraska, West Virginia

(table continued on next page)

1981 -Louisiana, Nevada, North Carolina, Utah, District of Columbia

1982 -Hawaii, Maine

1983 -Iowa, North Dakota, Oregon, (South Carolina - amendments and strengthened

1984 -(no changes)

1985 -Missouri, Texas, (W.Virginia amendments)

1986 -Alabama

1987 -Arkansas, Oklahoma

Only 24 percent of the states have no zoning laws for this population. They include:

Alaska, Georgia, Illinois, Kansas, Massachusetts, Mississippi,New Hampshire, Oregon, Pennsylvania, South Dakota, Washington ,and Wyoming.

The vast majority of these changes occurred during the late 1970's to early 1980's. Michigan was one of the first states in the country to change its zoning laws to accommodate expanded community services.

Each of these laws has varying components which shape the manner in which community expansion will occur. Some of the more common statute components include; (1) Type of community facility addressed, (2) Maximum number of residents allowed, (3) Type of residents, (4) Whether a conditional use

permit is authorized, (5) Whether state licensing is required, (6) Who licenses the facility, (7) How much dispersal is required, if any, among the facilities (distance) or as a percentage of population in that area.[30] A broad zoning law would allow group home developers so much discretion that they could virtually create entire blocks of large unlicensed facilities serving people with extremely diverse needs while a restrictive zoning law could make it difficult to develop community residential options whatsoever.

Michigan's zoning statutes allows for the use of six or fewer persons with disabilities, or aged, to be served in a foster care facility, provided that the home is licensed by the Dept of Social Services, and at least 1500 ft. away from another licensed home (3,000 ft. in Detroit).[31] The home must meet the other local zoning requirements for similar homes in that area. This particular statue and the support of the law by the courts seem to have allowed for a situation of 'controlled flexibility'. Deinstitutionalization has not been hampered by the zoning restriction and significant regulations are present to promote higher quality services.

Even when a state has no relevant state zoning statute in place advocates have successfully defended the rights of persons with developmental disabilities to be treated fairly. The one case where this is the most obvious and which has

been publicized the most, was summarized by Henderson and Vitello:

> ..On July 1, 1985 the U.S. Supreme Court decided a case dealing with the rights of mentally retarded persons to live as a family in a community-based facility (City of Cleburne, Texas v. Cleburne Living Center, Inc. 1985). The Cleburne Living Centers, Inc. (CLC) purchased a building in Cleburne, Texas, to establish a group home for 13 mentally retarded men and women. Neighbors expressed a number of complaints: The residents would be harassed by students in a neighboring school, the property was located "on a five hundred year flood plain," and a number of retarded persons would require supervision. Consequently, the city informed CLC that a special use permit would have to be approved before the property could be used for a group home. The city classified the group home as a "hospital for the feebleminded," which was the basis for denial of the special use permit under local zoning ordinance. CLC filed suit in a federal district court alleging that the zoning ordinance was invalid on its face and as applied because it discriminated against mentally retarded people in violation of the equal protection clause of the U.S. Constitution.[32]

The Court ruled in favor of CLC deciding that the city was

requiring this group to obtain a special permit even though other groups were not required to do so. A January, 1989 citation in the newsletter of the American Association of Mental Retardation provides information as to the final Cleburne conclusion:

> Cleburne Living Center received $145,000 in lost profit for the five years it was unable to operate..Advocacy Inc., the Texas Protection and Advocacy System, recovered $135,000 in attorney's fees under the settlement...Since September 1985 the home has operated without incident.[33]

The equal protection clause was an unquestionably effective position to employ in this case.

There appears to be some recent federal legislation which shows tremendous promise for deterring discrimination in rental or general housing. The Fair Housing Amendments Act of 1988 (PL-100-430), has been expanded to include non-discrimination guarantees for persons with disabilities. This provision may become another point of legal defense against neighborhood opposition to group homes in future years.[34]

Litigation is a double edged sword which has been used both to advance the movement to depopulate institutions and

also to block those individuals from moving into local neighborhoods. Both points shape the manner and degree that these persons are reintegrated into society. Michigan's circumstances with the Plymouth Decree, 1976 zoning amendments, and court cases leading to the 1985 Michigan Supreme Court ruling are not typical in their unified pro-community posture from the executive, legislative and judicial branches.

Public Funding

Federal funding for community based programs expanded dramatically from 1960 to 1985. In his book entitled, "Federal Policy Toward Mental Retardation and Developmental Disabilities, Braddock noted that federal spending increased from $118 million to $7.773 billion during this period for MR/DD services.[35] He went on to summarize the federal program changes as follows:

> Broad-based growth in federal MR/DD programs after 1965 was stimulated through congressional earmarks and special eligibility provisions attached to Great Society enactments.. During the seventies, the concept of developmental disabilities was introduced into law. New or greatly expanded programs were established in SSI, food stamps, Social Services, rehabilitation of severe

> disability, housing loans, and civil rights protections. The unprecedented expansion of health and special education services was authorized with the passage of the Medicaid ICF/MR amendment in 1971, and four years later of PL 94-142...The Reagan administration curtailed federal spending for social programs, and transformed certain categorical programs in public health and Social Services into administratively flexible block grants.[36]

Braddock also detailed the distribution of the total fiscal year 1985 Federal MR/DD funds as follows:

Table of MR/DD Funding - 1985

Program	**Total$'s** [37]	**% of Total**
Intermediate Care Facilities/MR	$2.657	34.2%
Supplemental Security Income	$1.533	19.7%
Aid to Dependent Children	$1.273	16.4%
Non-Institutional Medicaid	$ .930	12.0%
Medicare	$ .242	3.1%
Special Education Grants	$ .238	3.1%
Social Services	$ .215	2.8%
Food Stamps	$ .183	2.4%
Rehabilitation Grants	$ .134	1.7%
43 Other Programs	$ .368	4.7%
Total	**$7.773 Billion**	**100%**

Perhaps the two most recent programs which have had a dramatic impact on the funding of community based services were; (1) PL 94-142 of 1975 (Education of all Handicapped Children Act) and (2)PL 92-223 of 1971 (Title XIX or ICF/MR Amendments). The ARC was very active in lobbying for both of these bills.

1. Public Education for All Children

PL 94-142 authorized a portion of federal reimbursement for the excess costs of educating children with special needs from 3-21 years of age. This program was initiated to insure that all children would have access to educational opportunities.

Prior to the passage of PL 94-142 Michigan enacted PA 198 of 1971, which stipulated that special education services would be provided for children from 0-26 years of age. Clearly this early effort demonstrated this state's expanded commitment to serving these individuals.

When drafting P.A. 198, the supporters went in with a negotiation position of requesting a service range of 0-26 years, but they were apprentlywilling to accept 3-21 years. It was a fluke that the issue was never questioned by

the legislature. The result is that Michigan may have the most extended age limit for special education services in the entire country. When PL 94-142 was passed in 1975 it included much of the language found in Michigan's PA 198 which was considered to be progressive. Today all of the states have elected to comply with PL 94-142 with New Mexico being the most recent to comply in 1988.[38]

The ARC- Michigan played a major role in lobbying for this statute. They formed a coalition of interested parties, researched the language which would be employed and directed a petition drive which put the issue on the ballot. This issue had been a primary focus of this state organization.[39]

The indirect impact of these bills was to deter institutional placements by mandating the availability of educational services to families. Parents were now insured that they would not have to be independently responsible for providing 24 hour care to their son/daughter having a developmental disability.

2. Title XIX or ICF/MR Amendments of 1971

The manner in which institutions and community residences are funded was drastically altered by the

enactment of PL 92-223 of 1971 (ICF/MR). This law provides more than a 50% federal reimbursement for the costs of care in institutions that meet federal standards. These standards mandated improvements specific physical plant standards and required that active treatment be provided to their residents.

Federal funding of this program expanded from $36,872,000 for 12,188 recipients in FY 1972 to $2,572,336,000 for 141,079 recipients in FY 1984.[40] Early in the 70's states began upgrading their institutional programs to meet the ICF/MR standards. From fiscal years 1978 to 1980, states invested almost a billion dollars in capital improvements and expected to recoup those funds through extended ICF/MR reimbursements.[41] Michigan spent $64 million dollars for construction and renovation of state institutions during fiscal years 1977 to 1980.[42]

Lakin found that a large number of persons were de-institutionalized as an indirect response to the ICFMR regulations. Standards requiring a minimum square footage per bedroom per resident for example, necessitated either building larger institutions to accommodate the new requirement or placing people into community settings and using their existing buildings with fewer people therefore creating greater square footage per resident. Many states chose the latter alternative.[43]

The statute did not limit ICF/MR coverage to large (16+ persons) publicly operated settings or large privately operated congregate facilities. Although few states recognized this fine distinction and most did not pursue smaller community based settings for almost another decade. In 1981 the Health Care Finance Administration (HCFA) issued interpretive guidelines which clarified the national policy on small ICFMR's, however this was ten years after the original funding was available and it is doubtful that many states considered using these monies in smaller community based settings back in 1972.[44]

The vast majority of ICF/MR monies are still directed towards these larger (16+ person) settings. Therefore the federal government has in fact, encouraged maintenance of institutional settings. Braddock found that projected federal ICFMR reimbursements totaled $2.87 billion in FY 1986.[45] These funds were distributed among the settings noted in the following table:

Table of ICF/MR Funding Distribution

	Amount [46]	Percent
Institutional Services	$2,148,189,440	75%
(state operated 16+ beds)		
Community Services		
A. Small Public	$ 54,411.600	2%
(state operated 15 or fewer beds)		
B. Small Private	$ 318,253,670	11%
(private operated 15 or fewer beds)		
C. Large Private		
(private operated 16+ beds)	$ 355,900,514	12%
	==========	=====
	$2,876,756,224	100%

Clearly the smaller public (state operated) and small private settings account for only 13 percent of this entire pie, while the more institutional type settings account for 87%.

Michigan unlike many other states elected not to develop the larger private or small state operated ICF/MR's and has concentrated its community development in the area of smaller private ICF/MR's. This trend will be analyzed in greater detail further in this paper.

In 1981, the Omnibus Budget Reconciliation Act (OBRA) authorized a Home and Community Based Waiver which allowed states to secure less expensive community residential alternatives than ICF/MR institutional care. In FY 1986 these waivers totaled about 5% of all ICF/MR funds.[47] This is a minimal amount considering the entire ICF/MR program, but it favors smaller community based services.

Senator John Chafee (R-RI) recently introduced into Congress a the Medicaid Home and Community Quality Services Act of 1989. A similar bill was also introduced into the house by Rep. James Florio (D-NJ). These bills represent the most recent revision of legislation attempting to shift federal funding from larger institutions to smaller community residences. The first draft of this bill (S.1673) of 1983 received considerable opposition from unions serving institutional workers and those parents still preferring to have their son/daughter(s) receive segregated services.[48]

The ARC, TASH and other groups advocating for community services are concerned that the strong influence of those politicians from states having strong institutionally based service systems, such as Senate Finance Committee Chairperson, Sen. Llyod Bensten (D-TX), may lead to a watered down bill. There is widespread support of some type of medicaid reform. In 1988 there were 46 Senate cosponsors and 173 House cosponsors for the Chafee/Florio bills, which

was just short of a majority in both of the houses.[49]

One of the legislators who has been unwilling to endorse the bill is Rep. Henry Waxman (D-CA), who introduced his own bill in August of 1988. He has previously been identified as the key member in the House with respect to Medicaid policies. The bill he introduced would increase community funding while maintaining institutional expenses at their present level.[50]

The fiscal impact of both of these bills was estimated in 1988 by the Congressional budget office for upcoming Fiscal Years 1989-1993. Those tables are replicated below:

Estimated Fiscal Impact of H.R. 3454 (Chafee/Florio)[51]

Congressional Budget Office

Table 1

Estimated Federal Costs

(millions of dollars)

	1989	1990	1991	1992	1993
Increase in Recipients and Costs: Community Services	0	0	335	750	1140
Limitations on Payments to Institutions	0	-310	-640	-990	-1365
Administrative Costs	30	35	70	80	110
Total	30	-275	-215	-160	-115

Estimated Fiscal Impact of H.R. 5233 (Waxman)[52]

Congressional Budget Office

Table 2

Estimated Federal Costs

(millions of dollars)

	1989	1990	1991	1992	1993
Increase in Recipients and Costs: Community Services	0	25	25	30	35
Limitations on Payments to Institutions	0	0	0	0	0
Administrative Costs	1	6	7	10	13
Total	1	31	32	40	48

HR. 5233 would have taken $1365 million from institutional ICF/MR funding by 1993, increased community funding by $1140 million, increased administrative costs by $110 million, and decreased total ICF/MR costs by $115 million. H.R. would have maintained institutional ICF/MR funding levels as they are, increased community funding by $35 million, increased administrative cost by $13 million and total federal funding by $48 million. It is interesting to note that advocate groups who have fought adamantly for federal funding for this program prefer that Chafee/Florio bill which will cut the total federal ICF/MR funding rather

than increase it.

One way or another, it is likely that a bill will pass in the near future. What impact that legislation will have on shifting ICF/MR funds to community based services is yet to be seen.

Michigan has demonstrated its commitment to community based services not only through a rapid depopulation of persons living in institutions but also by financially supporting those families who continue serving their children with special needs at home. In fiscal year 1985, Michigan began funding an innovative family subsidy which provides $255/month to parents of severely mentally impaired persons provided that they are less than 18 years of age and the household income is less than $60,000.[53] In 1985 there were approximately 1600 families that received this subsidy.[54] In fiscal year 1989 there were more than twice that many.[55]

This program is directly geared to supporting those children, who would most likely have been institutionalized without some additional financial support. It has also been very cost effective especially when one considers that the $255 monthly payment is less than the expense associated with two days of institutional care at the U.S.average of $130.38 per day for fiscal year 1986. The Michigan rate noted by for this year was $177.59 per day, however this includes

services for people with very intensive needs.[56]

In summary, these historical factors have had a dramatic impact on the development of community based service systems during the past two decades. A considerable amount of the 50% reduction in the national institutional population during this time may be directly attributed to these factors. Changes in terminology, public awareness, advocation, litigation, and public funding continue to evolve and reshape these state coordinated services. Michigan's historical efforts with supporting community services through active advocate groups, early zoning amendments, favorable state court rulings, early provisions for encompassing special education services, family support subsidies, and commitment to small private community based ICF/MR's are not common in most other states. These historic factors surely have influenced the greater rate of institutional depopulation in this state as compared to the total national rate. But what does this mean exactly and to what degree have community services been expanded. A more detailed analysis of these issues will be discussed in Section V.

III. Literature Review

This section of the paper examines the empirical literature which identifies those explanatory factors that may justify variations in a particular state's mental health services for the developmentally disabled versus other states. Emphasis will be on reviewing those general factors, which are often associated with social science research, and specific factors which are directly related to mental health services. These components will be presented as follows:

General factors (demographic, political, economic and administrative)
Class Action Litigation
Comparative Costs and Benefits
State's Share of the Total Residential Expense

This information will provide the empirical foundation for comparisons used for the remainder of this study.

General Factors (demographic, political, economic and administrative)

In the spring of 1987, Hudson wrote an article entitled," An empirical model of state mental health spending," where he identified numerous factors which have

statistically significant independent variables which are shown to effect mental health spending. Their corresponding coefficients are as follows:[57]

Hudson's 1983 Spending Coefficients

	B	
1983 Spending:		
(R2 = 0.81, Adj. R2 = 0.74)		
Regions: Northeast	30.28	
Central	15.62	
Southeast	13.85	
Rate of suicide	0.99	
% of Population in metropolitan areas	13.04	
Taxation: regressive	-7.68	
Governor's power to appoint mental health director(Governor and one other)	-10.55	
1980 population density	-.02	
(Constant)	0.73	n.s.

n.s.- variable not significant

$p < .05$

Michigan, as compared to the national average, would have scored well with 1983 spending due to their combination of these related factors, specifically; (1) its geographical location, (2) lower rate of suicide from 1980-1983 (equal in

1979), (3) higher % of population in metropolitan areas, (4) higher population density, and (5) higher total population. [58, 59, 60, 61, 62] Furthermore Michigan's taxes are generally not as regressive as most other states. Sales and gross receipts for 1986 were 40% of the state total taxes as compared to 49% for the entire country.[63] This is further supported by the fact that their current 4% sales and use taxes rates are equal to or less than most other states.[64] The percentage of total state taxes collected from alcoholic beverages and cigarettes was 3.36% as compared to 3.29% of the U.S. total for 1986.[65] These are key indicators of the regressive tax nature of a state.

In Michigan, the governor has the power to independently appoint the mental health director, but his choice may be rejected by a two thirds majority vote of the senate, if done so within 60 days.[66] These seem to be the key components referenced in Hudson's finding.

The demographic and political factors which would have effected Michigan's 1983 mental health expenditures, should have placed this state much higher than many other states expenditures in 1983, according to Hudson's results because of Michigan's favorable ranking on each of these indicators.

This was supported by his findings which ranked Michigan sixth in 1983 mental health per capita spending at $32.00. [67]

The highest state was Delaware with $54.18 while the lowest was $10.32 in Iowa.[68] The average spending rate was $28.11 for this period.[69] From 1977 to 1983, Michigan was one of only nine states to increase their per capita spending by more than two percent.[70]

Mental health expenditures as referenced in Hudson's study generally include services for persons with mental illness in addition to those persons with developmental disabilities, plus mental health services for other persons without these labels. His research seems to indicate that Michigan's 1983 expenditures differed considerably from the mean expenditures, but this is difficult to determine without knowing the standard deviation.

Hudson also cited administrative capacity as being an additional explanatory factor which effects mental health spending.[71] The role of the department which is administering the program may be even more relevant when one examines how the mental health dollars are spent rather than solely if they are available to be spent. The former appears to be more of an administrative issue while the latter is probably more impacted by demographic and economic consideration.

The administrative factor as it specifically relates to institutional vs community spending efforts was further elaborated on in an article which appeared in the Social

Science Quarterly. The article was written in 1981 and entitled, "Social Service Innovation in the American States: Deinstitutionalization of the Mentally Retarded. The authors compared the deinstitutionalization of mentally retarded and juvenile offenders and basically found no correlation.[72] They found that,".. The lack of any appreciable relationship between these two types of deinstitutionalization may be rooted in the fact that communication and influence are often more extensive between decision makers in different states than between decision makers in different functional areas within a single state."[73]

This concept is supported by the geographical relationships noted in Hudson's study. The writers continued on to suggest that the political factor of legislative professionalism may play an important role. An efficiency minded legislature may further the goals of deinstitutionalization from an economic position. Even though the authors did not believe that this type of savings had yet been fully proven they believe that the public perception is that it will be more cost effective. This justifies a the depressed correlation between deinstitutionalization and a states affluence, which they observed, since even the poorer states would be attracted to the cost saving appeal of deinstitutionalization.[74]

Michigan's full time legislature and the economic perils

facing the state during the past decade, would have provided both the incentive and the means for a higher rate of depopulation according the rationale stated in this article.

A state's affluence as an explanatory factor in this equation was also rejected in a latter study by Braddock et al,(1987).[75] He examined the mental health spending patterns for all 50 states and the District of Columbia for fiscal years 1977-1984 and determined that:

> State size and wealth are poor predictors of MR/DD fiscal effort. The absence of stronger correlations among the study variables, particularly in the community sector, no doubt reflects the complex dynamics of MR/DD spending policies in the states. Certainly, more meaningful explanations of state MR/DD fiscal effort will require analyses of sensitive state-specific determinants..There are many potentially important determinants, the most common of which includes strong gubernatorial and/or legislative leadership, class action litigation, the presence of mature consumer and professional interest groups, active media, and a positive attitude of key state agency personnel toward community innovation...[76]

All of these 'determinants' suggested by Braddock are ones which Michigan can boast having in place especially during

the early 1980's. This was just after the period when the 1979 Plymouth consent decree was issued. In 1982 Governor William Miliken (R) did not pursue reelection, after serving numerous terms, and was replaced by Governor James Blanchard (D) who was elected by comfortable margin. As previously indicated in Section II of this paper, the ARC had assumed a major role with state advocacy which traced back to the late 1960's. The media had been very involved with continued television coverage and newspaper articles related to institutional 'horrors', and community group homes as they related to zoning issues. The attitude of the key mental health administrators was also positive towards change. The comprehensive combination of these factors was not something that many other states could boast at that time. There were many differences in the class action litigation cases alone.

Class Action Litigation

Class action litigation has not always solved the problem of shifting funds and services to community settings. Perhaps the earliest class action suit noted throughout the literature is the Wyatt v. Stickney 1971 case which involved an institution in Alabama. The order stipulated that persons residing in the institution have a right to proper treatment. This allegedly led to massive deinstitutionalization.[77] The problem was that the order did not include sufficient

guarantees for the provision of small community based residential services. In fiscal year 1986 Alabama ranked 48th out of 51 states (and D.C) in these types of expenses as a share of that state's total personal income.[78]

This section of the paper analyzes the process involved with class action litigation and its effectiveness in more detail.

Some authors have strongly objected to the manner in which advocates utilize the courts to promote improved services. In the Fall of 1986, Robert Curtis, an obvious opponent to these actions published an article entitled, "The De-institutionalization Story," where he portrayed this event by advocates as follows:

The strategy adopted in state after state followed a rather similar pattern:

1. Select a state institution that is obviously overcrowded.
2. Identify several parents or relatives who are critics of the institution, then gain their support as future witnesses in federal court and obtain permission to use their relative as an example of a victim of state decision making;
3. Identify disgruntled (or recently fired) state

employees who will also testify about institutional conditions;

4. Contact the press about the impending suit;
5. Sue the state in federal court for violating the constitutional rights of residents because of the quality of institutional care based upon the facts testified to by these parents and employees;
6. Convince a judge to permit a class action suit by all residents living at the institution so that relief given to named parties will be extended to every resident;
7. Begin discovery of all state records related to the institution and seek court permission to visit the institution at will.
8. Take photographs of the most awful conditions to be found or to be created by working -but- disgruntled employees;
9. Demand documents that are impossible for the state to produce:
10. Conduct motion sessions before a federal judge during which the state is accused of not dealing in good faith and of attempting to hide the horrible conditions it has created;
11. Report these events to the press. [79]

Mr. Curtis probably reflects the opinion of many public administrators who are confronted and frustrated with

litigation of this type.

This process also has objections from advocates. In April of 1989, I spoke with Judith Gran an attorney for the Public Interest Law Center of Philadelphia, which has been involved with numerous deinstitutionalization and community services suits presently including:

1. The Hissom Court Order in Oklahoma- which is currently being appealed by that state in Circuit Court.
2. A suit which has recently been filed in New Mexico against several institutions in that state (1986 Community Expenditure Ranking of 36th)[80]
3. A suit in filed in Illinois against several large private ICF/MR's [81]

One problem which she cited was that it becomes difficult to track some of these settlements when a host of different parties (especially the U.S Justice Dept.) agree to," quick and dirty," settlements which are less effective than what some of the more specialized advocate groups would have agreed to.[82] This action may then provide an effective barrier to further litigation and also may be difficult to track. One such settlement had recently occurred in Oregon. She wasn't yet sure what the direction of the Justice Department under the Bush Administration would be.[83]

In addition to the problem of tracking these orders and decrees, there are also problems isolating what impact they have. Some states begin improvements in their institutions and develop community services after a court order is filed, but long before a settlement is reached. Some make no changes until the court orders are issued. Some had plans to make those changes anyway irregardless of any pending legal action. Each of these options must be considered in this analysis.

James Conroy and Valerie Bradley are Principal Investigators who have been involved in a five year longitudinal study of the closing of the Pennhurst institution listed the following factors associated with a state's response to litigation:

1. Level of sophistication and development of existing state mental retardation system.
2. Extent of public pressure for reform.
3. Explicit or implicit agenda of state officials.
4. Orientation of the states political leadership.
5. Nature of the relationship between state program official and state lawyers.
6. Extent of previous litigation in the state.
7. Judicial strategies employed by the federal judge in contested and uncontested cases.

8. Nature of the decree and monitoring mechanisms established.
9. Strategies employed by the plaintiffs.
10. Level and distribution of state resources.[84]

The Plymouth decree in Michigan was not a heated contested battle through the courts, but more of a formalized negotiation among the parties. There was widespread consensus that reform was needed. Advocates and state officials worked together to provide a settlement which mandated substantial changes in mental health residential services. Key administrators supported these changes as demonstrated by closures of four additional institutions not specified in the decree. According to Gran there's generally a lag period of almost two years before the full effects of this type of litigation is realized.[85]

Some orders/decrees are much more extensive than others. One apparent dividing line between an effective one and those which are less effective, is whether the order stipulates that the institution cited, must specifically depopulate its residents into the community. The following table was created by matching only those major cases having these qualities with Braddock's 1986 community expenditure ranking data.

Court Orders/Decrees Requiring Depopulation

State	FY 1986 Rank * Comm.Spending	Order/Decree** Years)
District of Columbia	3	Decrees ('78,'83)
Florida	28	Decree ('85)
Maine	10	Decree ('81)
Michigan	5	Decree ('79)
New York	8	Decree ('75-'84)
North Dakota	2	Order ('83)
Oklahoma	51	Order ('87)
Pennsylvania	9	Order ('76 -'85)
Rhode Island	1	Decree ('82)

* - (excludes large 16+ person community facilities) [86]

** - Pilcop complete list of citations in Appendix B. [87]

All of these entities rank in the top 10, out of a possible 51, on community based expenditures as a percentage of state personal income except for Florida (28th) and Oklahoma (51st). Both of these states had court action during or after the year in which Braddock's 1986 statistics were compiled. Based upon these statistics it is likely that they will also advance dramatically with their comparative ranking in proceeding years.

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Michigan's ranking of 5th demonstrates one measure of their excellence in this area. All of the other states which ranked in the top ten on Braddock's scale were also acting under some form of court order or consent decree. I reviewed all of the court orders and consent decrees referenced by Pilcop. The only other class action which appears to be more comprehensive than the Plymouth decree, with respect to depopulation, and emphasis on financially supporting small community based residences/programs, is the Hissom court order of 1987.[88]

Comparative Costs and Benefits

Previously mentioned was the difficulty in performing cost comparisons of institutional and community residential services. This will be examined in more detail here since it is a key determinant in the institution versus community services decision.

Frequently those person who are first placed out of institutional settings are the ones who can perform most independently and are most likely to succeed with minimal supportive services in the community. As the numbers of persons in institutions decline and the intensity of needs increases, the institutional costs per person also increases.

If these higher costs are then used to compare to the costs of community services than the community services will be less expensive. So when comparative studies are conducted one must insure that similar populations are being compared and that the costs are specifically being charged to the person to whom they are provided.

There are other benefits which must also be taken into consideration such as the more normalized environment which is provided in a group home and the potential for greater developmental improvements.

One study which appears to have obtained both specific cost and services data was conducted from 1978 to 1980 on 140 people. This included 70 people who left Pennhurst institution moving into Community Residential Facilities (CRF's) that were closely matched with 70 people who stayed at this Public Institution (PI).[89] The following analysis was made by these researchers:

> ...In this study, the results suggested that the CRF programs were associated with increased personal independence, greater quantity of services delivered, and less public expense. The conclusion that the CRF programs were more cost-effective than the PI program appears to be warranted...[90]

The study went on to say that the costs of care were less in the CRF's but that this was due to the fact that community service employees providing direct care earn much less than their institutionally based counterparts.[91]

Residential programs are very labor intensive services. Personnel costs for employees working in group homes serving people who have been deinstitutionalized over the last decade, often comprise the vast majority of the home budget. It is not uncommon for these employees to receive salary and benefits equivalent to approximately 50% of that earned by institutional workers. With comparable pay the cost of many community residential programs would exceed the cost of institutional programs. In essence the burden for making this program more cost effective is carried on the shoulders of community workers.

State Share of the Total Residential Expense

Some residential programs, both institutional and community based, are eligible for ICF/MR federal funds while others are not. Deinstitutionalization may effect that portion of the total cost of care which the state pays. In fact this was found to be true in the Pennhurst study. The researchers noted that:

> The federal Medicaid program (Title XIX, ICF/MR) reimbursed the state in which this study occurred (Pennsylvania) for 55% of the cost of services rendered in the PI. No equivalent federal participation pertained to the CRF programs. The CRF programs were, less expensive to society, and they placed less of a burden upon the federal tax base. Conversely the CRF programs placed a greater burden upon the state tax base.[92]

If these individuals had been placed in small community based ICF/MR's then the state's share of this expense would not have increased and the total state expense would have decreased. However during the time in which this study was conducted many states had not begun efforts to develop small community based ICF/MR's. Michigan was one of the first states to do so in 1978 as part of its Alternative Intermediate Services for the Mentally Retarded (AIS/MR) program.[93] Prior to that time Michigan also funded other community based residential services. All small community based homes which contract with the Michigan Department of Mental Health are typically managed by non-profit corporations. AIS/MR and other Michigan residential settings will be reviewed in Section V of this paper.

Sometimes specific states were mandated by a order or decree to depopulate their institutions quickly. This may

have resulted in earlier community development efforts as compared to other states but also in greater state total expense, if federal funding was not available at that time. In recent years Michigan has attempted to convert some of its non-federally reimbursed homes over to the AIS/MR homes which do receive these funds.

One interesting and significant correlation which was noted by Braddock in his study of the spending patterns from 1977 to 1984 was that the more the federal government spends on institutional care, as a percentage of total personal income, the less share the state will spend for institutional care.[94] The implication is that the federal government is not only spending the majority of the largest federal funded MR/DD program on institutionally based services, but the more it spends for those services the less the states spend. Since the overwhelming consensus is that community services are preferable, medicaid (ICF/MR) reform is long overdue.

In summary, the empirical studies reviewed suggest that numerous general and mental health specific factors play a predominant role in both how much will be spent for these services and how they will be spent. State size and wealth are not valuable indicators of progressive programs. Nor does the presence of other innovative state programs necessarily result in generalization to mental health programs. Geographic, political, general economics,

administrative, class action litigation, program costs/benefits and federal funding considerations do account for much of the variation in a states fiscal efforts and the types of services provided.

IV. Methodology

The data utilized herein were obtained from a variety of different statistical references, books, and personal contacts with various mental health agency representatives. Attempts were made to gather information for the entire 1977 to 1986 Michigan fiscal year period, and for each of the 50 states and the District of Columbia when possible.

The sources utilized and primary information sought for this analysis are detailed below:

Primary Data Sources

1. Data for all States and the District of Columbia

U.S. Department of Commerce, (1986).Statistical Abstract of the United States. Washington, D.C.: U.S. Government Printing Office, Appendix B, B-7.

- population, personal income data for Michigan fiscal years 1977 to 1985.

U.S. Department of Commerce, (1987).Statistical Abstract of the United States. Washington, D.C.: U.S. Government Printing Office, pp 23, 425.

- population, per capita income data for Michigan fiscal year 1986.

It should be noted that the fiscal year periods indicated on the U.S. census data is not consistent with the Michigan fiscal year period, however this difference is not expected to have a dramatic effect on these findings.

Braddock, D., Hemp, R., & Fijuiura, G.,(1986). Public Expenditures for Mental Retardation and Developmental Disabilities in the United States: State Profiles (Second Edition). Chicago: University of Illinois, Public Policy Analysis Program.

- institutional population census, federal financial participation rates, federal income maintenance funding, community funding (state and federal), institutional funding (state and federal),.

2. Michigan Data

Michigan Department of Mental Health, Michigan Cost Profiles of Agencies for the Developmentally Disabled, Lansing, Michigan.

- institutional expenses, AIS/MR expenses, other residential services expenses.

Separate profiles researched for fiscal years 1980 to 1986. Other years were not available.

Telephone interview with Vicky Rowley, Mental Health Finance, Michigan Dept. of Mental Health, Lansing, Michigan, March 31, 1989.

- residential services per diems (she referenced the cost profiles cited above).

Telephone interview with Joe Frick, Financial Reporting Section, Office of Accounting, Michigan Dept. of Management and Budget, Lansing, Michigan, March 20, 1989.

- Dept. of Mental Health total general fund expenses, and total state general fund expenses.

Telephone interview with Tom Deloach, Director, Office of Communication, Michigan Dept. of Mental Health, Lansing, Michigan, March 21, 1989.

- AIS population census 1985-1986

L. VanDesande, Office of Public Information, Michigan Dept. of Mental Health, Lansing, Michigan, December 3, 1986. (Mimeographed material)

- AIS population census 1977-1984.

Data Adjustments

This primary information was then processed to produce the graphs which are presented in the findings of this paper.

Two key adjustments were made to the data:

1. Personal Income -

   The model utilized by Braddock et al., (1986) of converting monetary figures to a percentage of that states total personal income was employed here. This allows for greater control of state by state variation effected by unstablilizing factors such as inflation rates, and regional buying power.

2. Population -

   The conversion of institutional and other residential census data to a share of that state's total population was performed to control for state variations.

These adjustments standardized the data, so that each state and District of Columbia could be examined as an equal partner 1/51 of the final analysis. Henceforth the term 'states' will include the District of Columbia.

Several key areas were then examined:

Michigan's economic situation as compared to the other states. The goal here was to determine what the different economic climates were that may have effected the state's expenses for developmental disabilities.

The general fund expenditure data for Michigan were also examined. Of specific interest, was what amounts were allocated to the total mental health program, and program for the developmentally disabled. This information allowed for the comparison within the state to determine; (1.) whether state funding for developmental disabilities increased or decreased its share of the total state funds and (2) what impact DD funding had on other state programs. Only general fund expenses were examined rather than total state funds, since the latter figures include special revenues which provide extensive fluctuations from unrelated sources (lottery sales, etc.).

The actual expenses for mental health services for the developmentally disabled in all the states were examined in greater detail. Institutional and community expenses were adjusted to remove all large private ICF/MR funds (federal and state) from the community line items and forward them on to the institutional line items (federal and state). The purpose of this adjustment was to disregard the obvious institutional orientation of these larger settings. Much of this basic Michigan expenditure information (as a % of personal income versus years) is a reproduction of work performed by Braddock, however these percentages were independently calculated using only his expenditure data. The key difference is that this research provides a

comparison of the Michigan data versus the mean results for all states rather than the total for all states. The mean statistic allows for greater equalization among the states.

Specific expenditure data were then manipulated to calculate the standard deviation for each year and Michigan's corresponding position (z score) assuming a normal distribution. This score was then used to establish Michigan's position on the following standardized rating table.

Table of Standardized Ratings

Rating	Standard Deviations [95]	
95% +	1.65 +	
90%	1.20	
80%	.84	
70%	.52	
60%	.25	
50%	0.00	(mean)
40%	-.25	
30%	-.52	
20%	-.84	
10%	-1.20	
5%	-1.65 -	

(For the purposes the assumptions stated in Section V of this paper 15% or 85% would indicate approximately 1 standard deviation from the mean.)

This provides a model for us to more readily compare Michigan's performance versus that of the other states for that particular expense and further allows for standardized comparisons between expense categories. If the variation between the mean of all states and Michigan's rating is significant, one can better identify and examine that occurrence.

Linear regression was utilized to explore the relationship between the dependent variable of institutional services funding and the independent variable of institutional population. The purpose of this examination was to identify trends with respect to these variables.

Little information is nationally available on how many people are being served by the state community funding. This research provides greater detail as to the actual percentage of Michigan's population served by institutions, AIS/MR homes, other DMH residential services, and conservative estimates for the remainder of the population having developmental disabilities in Michigan. These statistics are compared with the funding levels for each category thereby demonstrating their shifting trends.

A Lotus spreadsheet program was utilized to manipulate the data, calculate the statistics, and graph the results. The national data involved 510 cases (51 states x 10 years).

The population, personal income, and DD expenditure numbers (from Braddock et al., 1986) were individually rechecked and all totals verified. Most of the Michigan DMH residential services data which is not compared to other states, was assembled from other sources when possible. This may cause some variation in these amounts between these graphs, but these alternative sources were based entirely upon actual expenditure data rather than budgeted amounts, which were sometimes used in Braddock's data.

In summary, this comprehensive examination of Michigan's mental health services for the developmentally disabled, not only explores the shifting trend from institutional to community based services and what the impact of this trend has been, but also builds upon the model for similar studies by incorporating standardized ratings into this process. Both issues will be scrutinized in greater detail in Section V of this paper.

V. Assumptions/Findings/Analysis

There are many different trends which may be examined based upon the proceeding information. Issues relevant to the national trend have been bypassed to allow for close examination of Michigan's experience as it may vary from the national average. Only that period from fiscal year 1977 to 1986 will be considered.

Foremost is an analysis of the economic climate in Michigan during this period. This is followed by a national comparative analysis of:

Total DD Funds =

- Federal Income Maintenance (FIM)
- Total Federal Funds
- Total State Funds

Michigan's state funding share for this program is comprised of 93-95% revenue from state general revenue funds.[96] The proportion and amount of state funding in Michigan is somewhat unique and therefore is explored in greater detail. The national comparisons will then continue with:

Total Institutional Funding =

- State Institutional Funding
- Federal Institutional Funding

An analysis of institutional funding trends as they relate to institutional population is also presented. A more detailed review of Michigan's community funding and services data is then provided to complete these findings.

Michigan's trends, with respect to the above stated areas, have been examined to some degree by other authors. Michigan's unusually high total mental health spending level in 1983 was noted by Hudson.[97] Braddock prepared numerous detailed individual state graphs for ten years of DD expenditure data which demonstrated:

- the shifting trend of Michigan's community expenses from a majority of institutionally based to community based services in beginning in 1982 and continuing through 1986.
- a sharp reduction in Michigan's institutional population during this period.[98]

The format utilized for many of the Michigan expenditure graphs included in this paper are a duplication of his work. His research also ranked each state's efforts with respect to community and institutional expenses. Michigan ranked forty-ninth in institutional expenses and fifth in community expenses in 1986.[99]

This paper examines this funding in greater detail, with

respect to the entire national distribution and pinpoints Michigan's position in that range. Furthermore, additional data solely related to Michigan are presented.

For purposes of the remaining sections of this paper the term dramatic refers to at least 1 standard deviation from the mean (average of all states).

Assumptions

This trend of a sharply shifting emphasis towards community services, which began in fiscal year 1981-82, is not surprising considering that this particular time was two years after the Plymouth Decree was rendered. Normally this is the lag period for these actions to be apparent. Based upon the extraordinary factors noted in the previous sections of this paper Michigan should show dramatic differences in their community and institutional funding versus the national average. One might therefore assume the following:

1. Total DD funding, FIM, state and federal funding will exceed the national average.
2. Total institutional funding will drop dramatically below the average, as will institutional services.
3. Total community funding will increase dramatically beyond the average, and community residential services will expand primarily to serve the

newly deinstitutionalized population.

Before checking these assumptions the economic turmoil facing Michigan during this period is examined to present a proper background of these relevant financial issues.

General Economics (Graphs #1-#6)

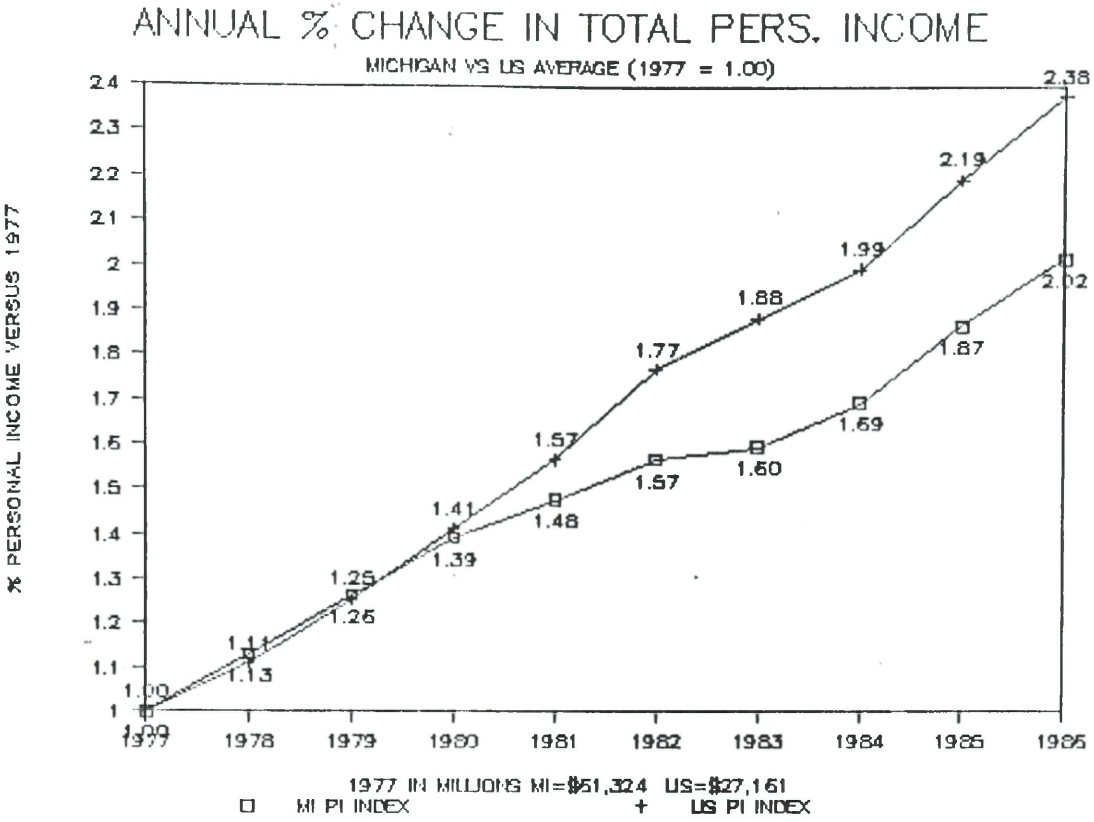
Graph #1 demonstrates that in 1977 (base year), the total personal income in Michigan was almost double the national average; however by 1986 personal income in Michigan had increased by 102% while the national change was 138% for the same period.

Graph #2 demonstrates that during fiscal years 1978 and 1979 Michigan's total percentage change was greater than the national average, but since that time it has dropped sharply in 1980 and 1981 to below the mean and has remained dramatically below the mean after that time.

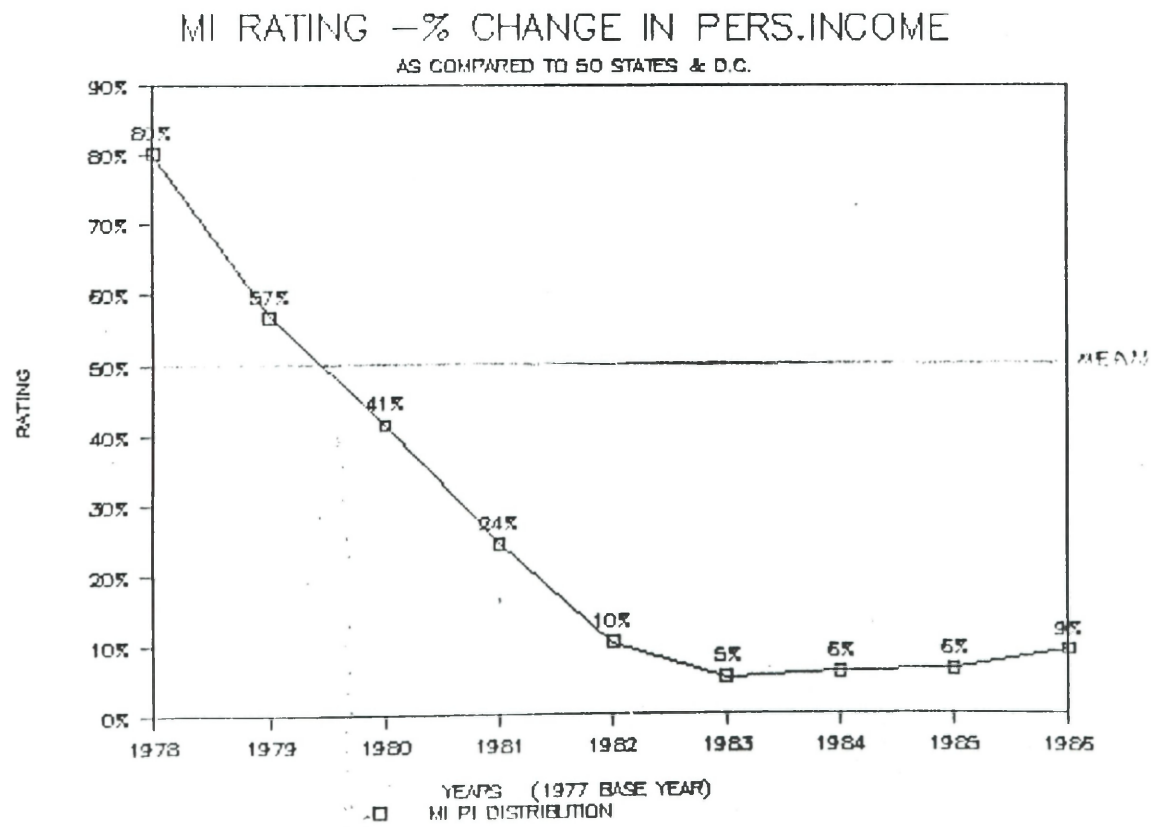
Graph #3 confirms that the national mean percentage change in population increased by 11.3 percent from 1977 to 1986 while Michigan's rate dropped .3% during the same period. The greatest variation occurred after 1981.

Graph #4 shows that Michigan's population change was much less the the mean throughout the period but it was not

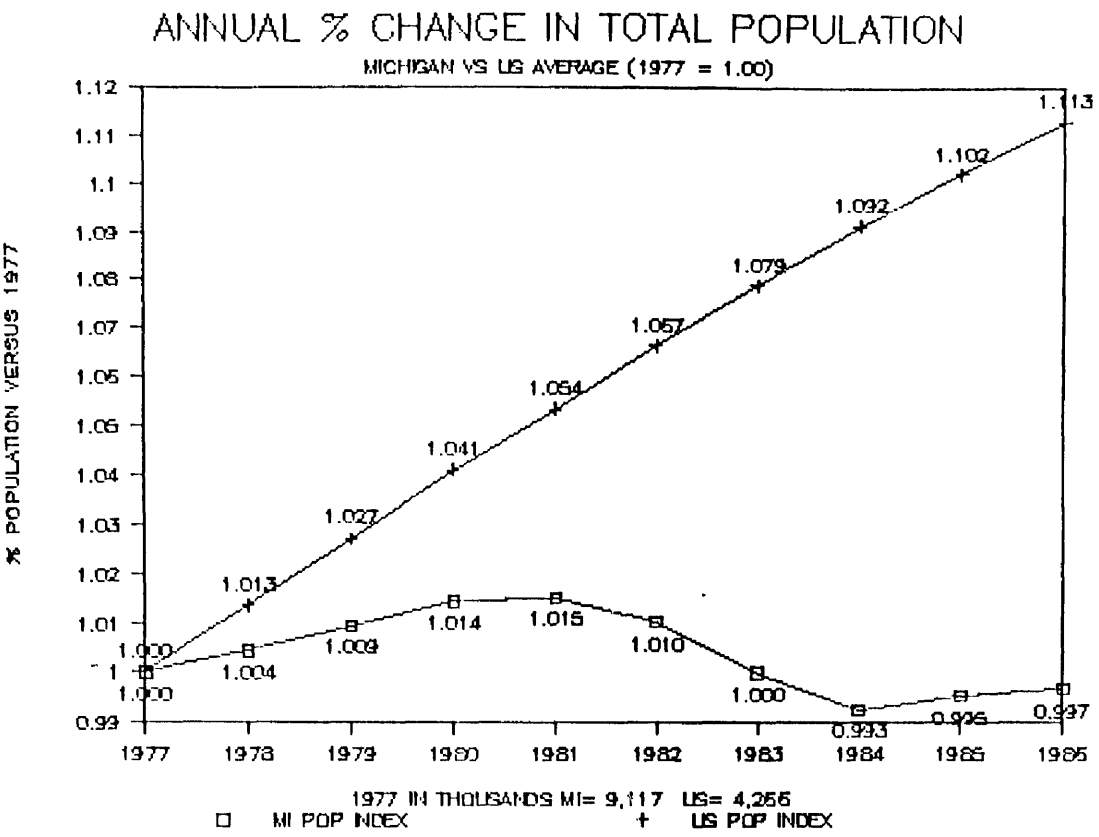
Graph #1



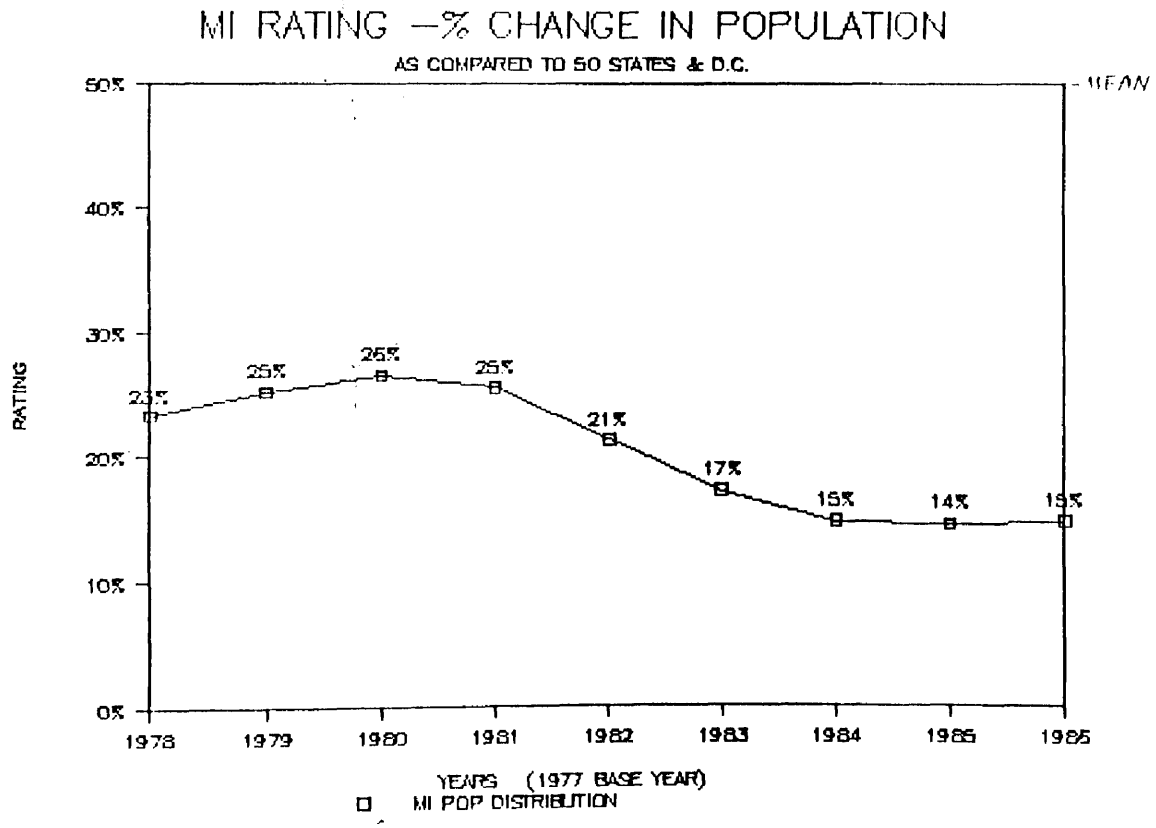
Graph #2



Graph #3



Graph #4



until 1984 that it fell dramatically below the mean where it remained throughout fiscal year 1986.

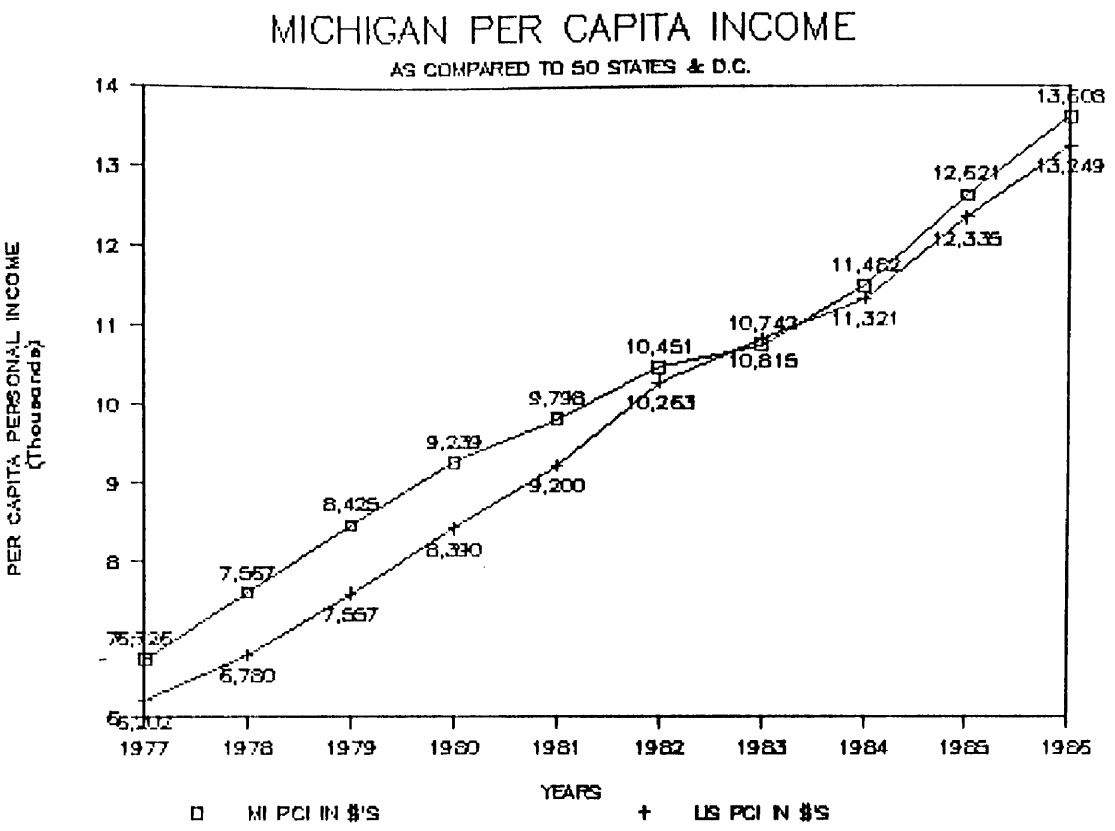
Graph #5 verifies that Michigan's actual per capita income continued to be higher than the national average except for year 1983, when it fell $73 below the average.

Graph #6 demonstrates that Michigan's highest rating of 79% in 1979 was well above the mean but this amount dropped sharply to 48% in 1983 and then increased to 57% in 1986.

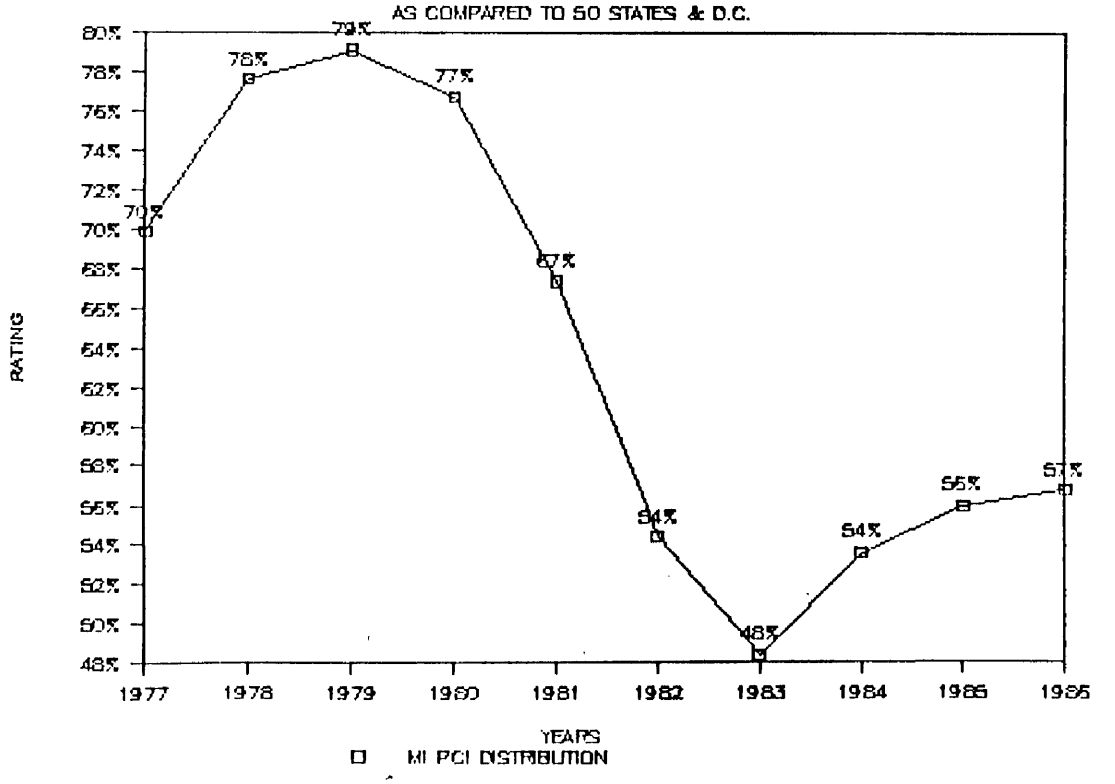
Each of these economic indicators demonstrates that the economic turmoil confronting Michigan began in 1980 and continued throughout 1986. Both the personal income and the population indicators remained dramatically lower than the U.S. average in 1986. Since a higher population is not necessarily associated with a higher standard of living, the per capita income indicators are more relevant predictors. They showed that Michigan has lost alot of ground from their 1979 position, but improved gradually since the 1983 low.

It should be emphasized that many of the subsequent statistics utilize a state's personal income or population in their denominators. Since these amounts have not increased in Michigan comparably to the national average, the corresponding Michigan expenditure statistics would automatically appear higher. A lower denominator with the

Graph #5



Graph #6



same numerator will automatically result in a higher percentage of personal income. Since the Michigan population census has not increased like other states, the percentage of persons served will also be higher than other states with all other things being equal.

It is not expected that this situation will significantly alter the result of this study or portions thereof, however it does warrant consideration.

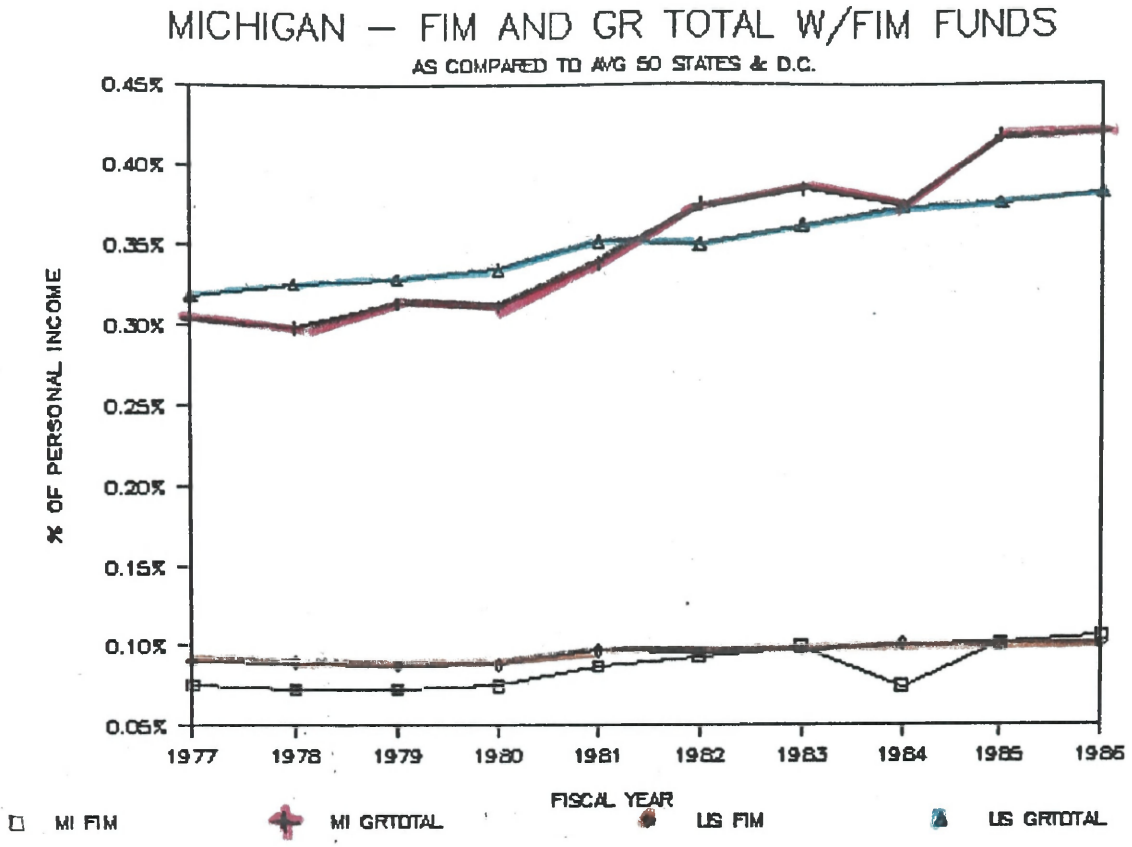
Total DD and FIM Funds (Graphs #7-#8)

Graph #7 demonstrates that the total DD and FIM funding in Michigan exceeded the national average after 1981 as expected except for year 1984. This appears to be the result of a potential error in Braddock's FIM data rather than a true decrease for 1984.[100] This FIM amount includes Supplemental Security Income (SSI) and Childhood Disability Income (SSDI) and was not included in the remaining national comparisons presented here.

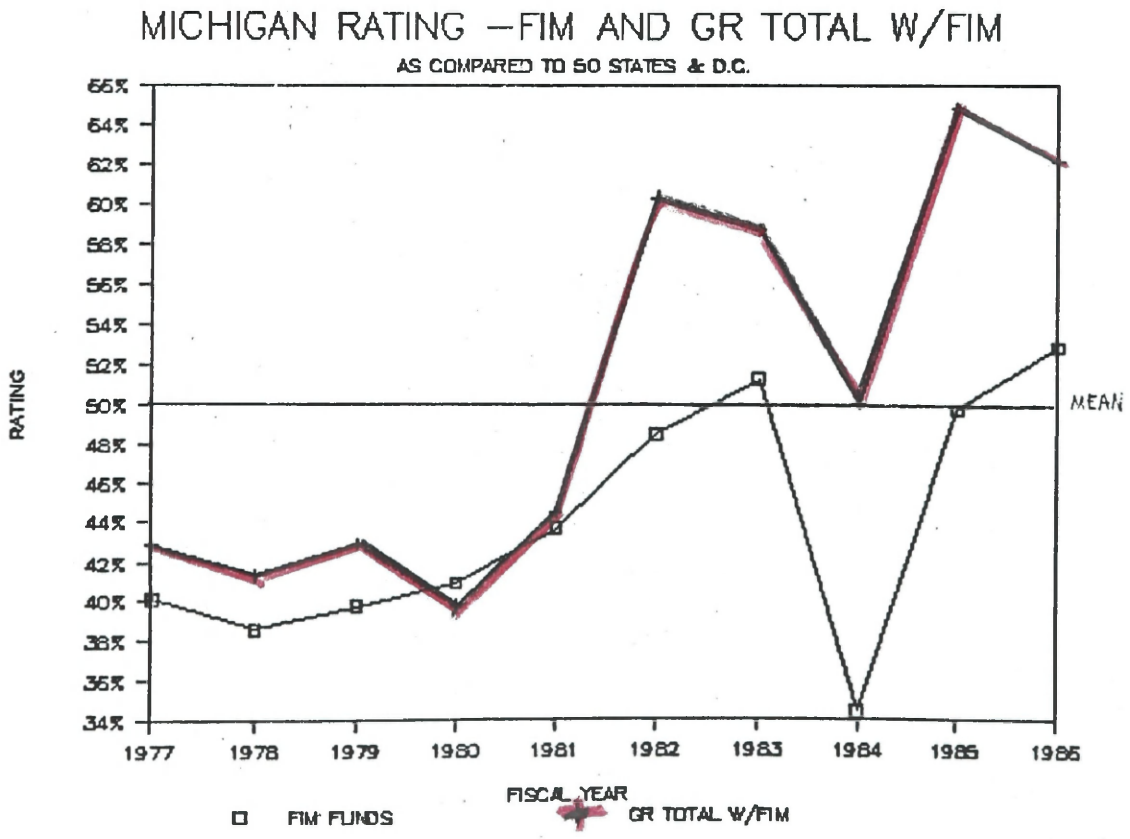
Graph #8 shows that, excluding the suggested FIM error, Michigan has scored well above the national mean since 1982, but has not been dramatically beyond the mean.

A community based program is alleged to be economical, therefore greater total expenditures are not necessarily

Graph #7



Graph #8



warranted. Although when one considers that the 1979 litigation in Michigan mandated continued community services and specific rates of depopulation, it was assumed the total DD expenses, FIM, state and federal funding would increase somewhat in each category beyond the mean. This assumption was made due to the expectation that greater costs would be associated with these rigid time frames and standards. The findings suggested that this assumption held true for the total DD expense and FIM categories.

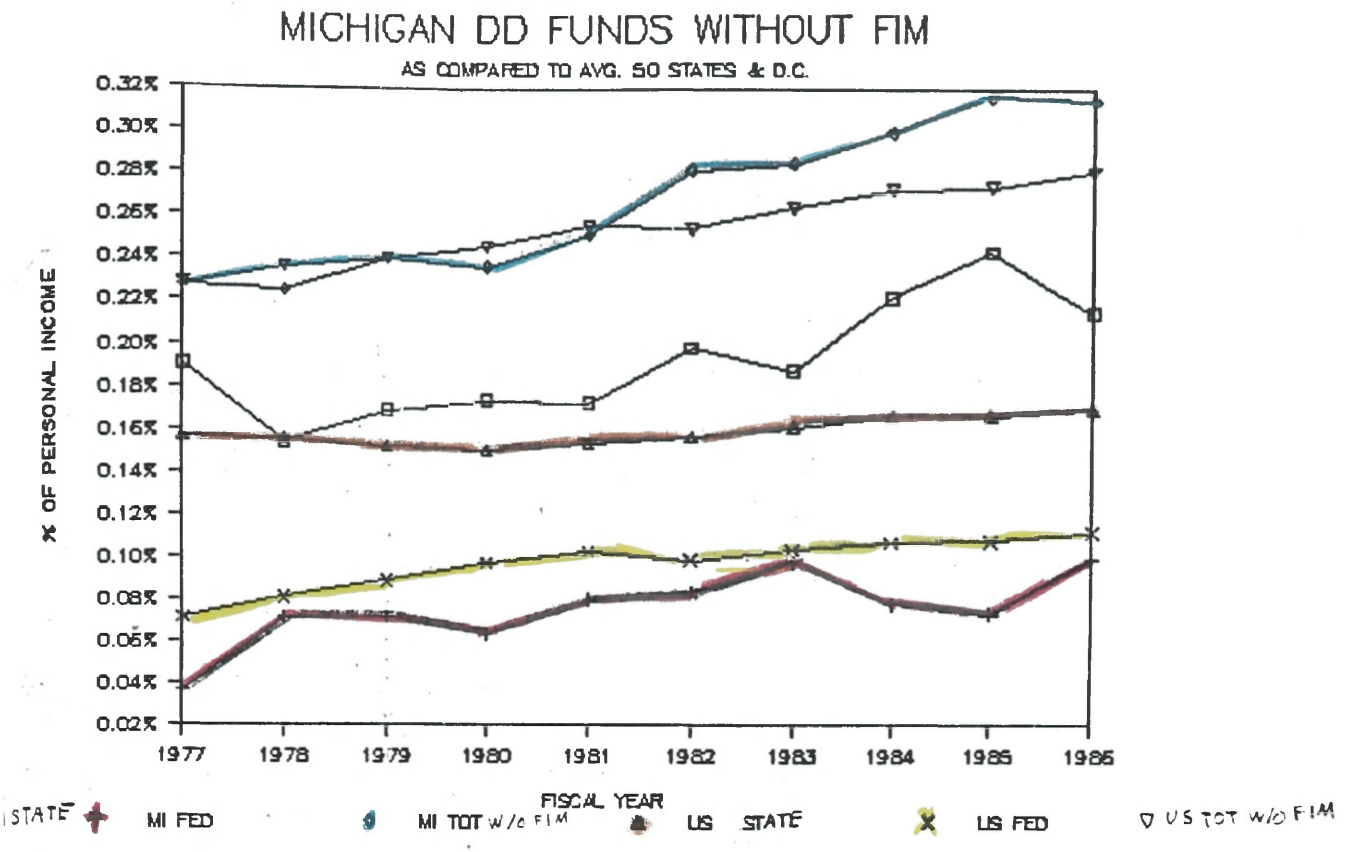
Total Federal and State Funds (Graphs #9-#10)

Graph #9 depicts Michigan's higher total DD funding after 1981 (excluding FIM), higher state expenses after 1978, and lower federal expenses throughout the period, as compared to the national average.

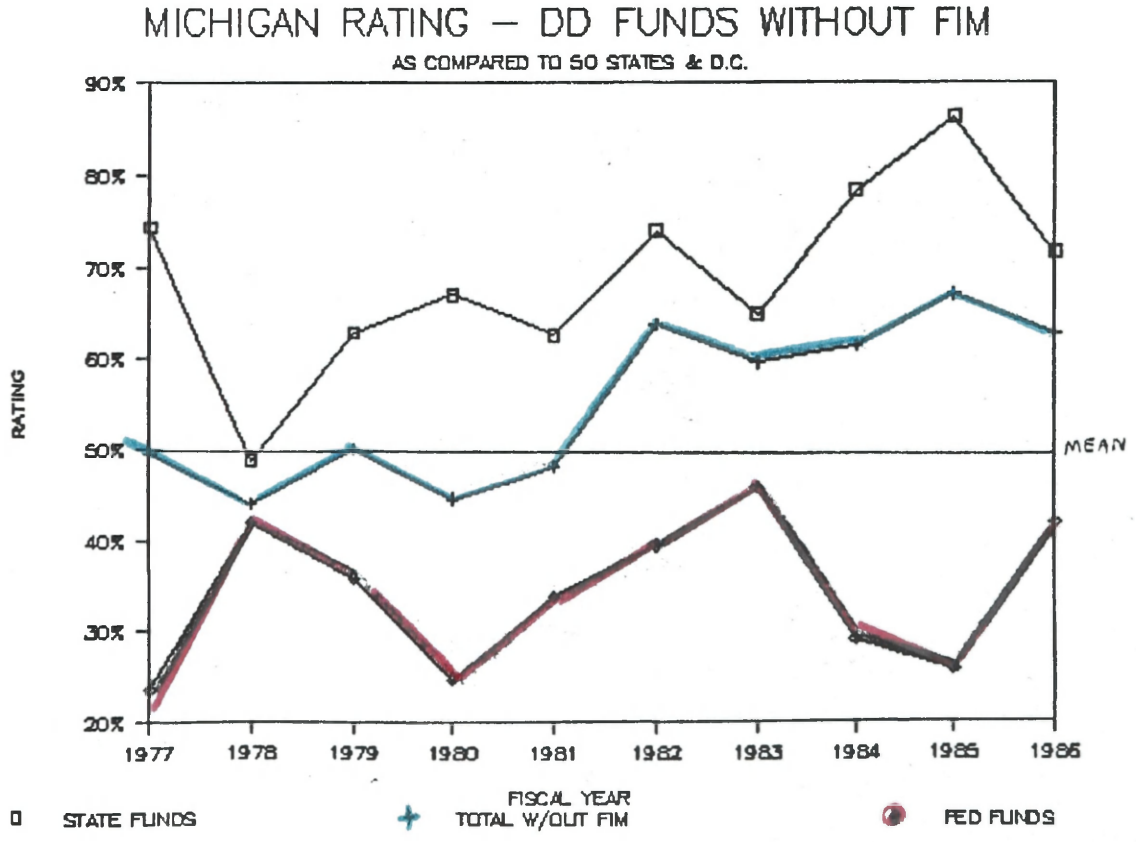
Graph #10 shows that the total DD funding is not that much higher than the mean; however the total state funding is almost dramatically higher and the total federal funding is almost dramatically lower than the mean at several points during this period. There appears to be a negative correlation between total federal and total state funding during this period. Braddock noted this correlation with institutional funding but not with total DD funding.

Therefore the part of my first assumption that total DD

Graph #9



Graph #10



funding, FIM and state funding would be higher was supported, however the part of that assumption which related to higher federal funding was not. Michigan appears to be funding much more of its DD services with state rather than federal funds as compared to other states. Michigan's use of general funds for DD services will now be analyzed in greater detail.

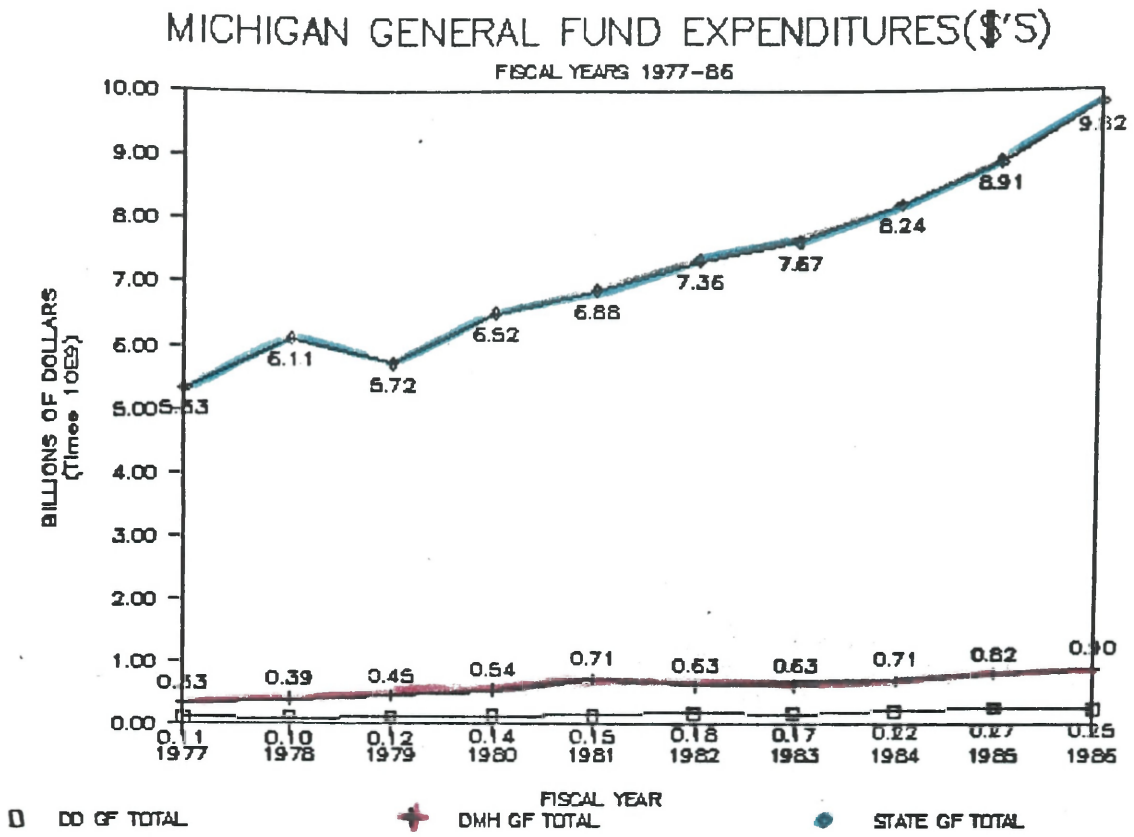
Michigan General Revenue Funds (Graphs #11-#14)

Graph #11 depicts the actual general fund expenses in Michigan for the period. Total expenses rose each year except in 1979. DMH expenses roses sharply in 1982 to accommodate an accounting change from legal to gap accounting methods, and erase a corresponding deficit.[101] Otherwise the DMH expenses would have shown a steady increase throughout the period. The DD expenses dropped in 1978 (just before the Plymouth class action litigation), in 1983 and also in 1986 (which is a somewhat questionable statistic considering the trend and the date the data were collected).

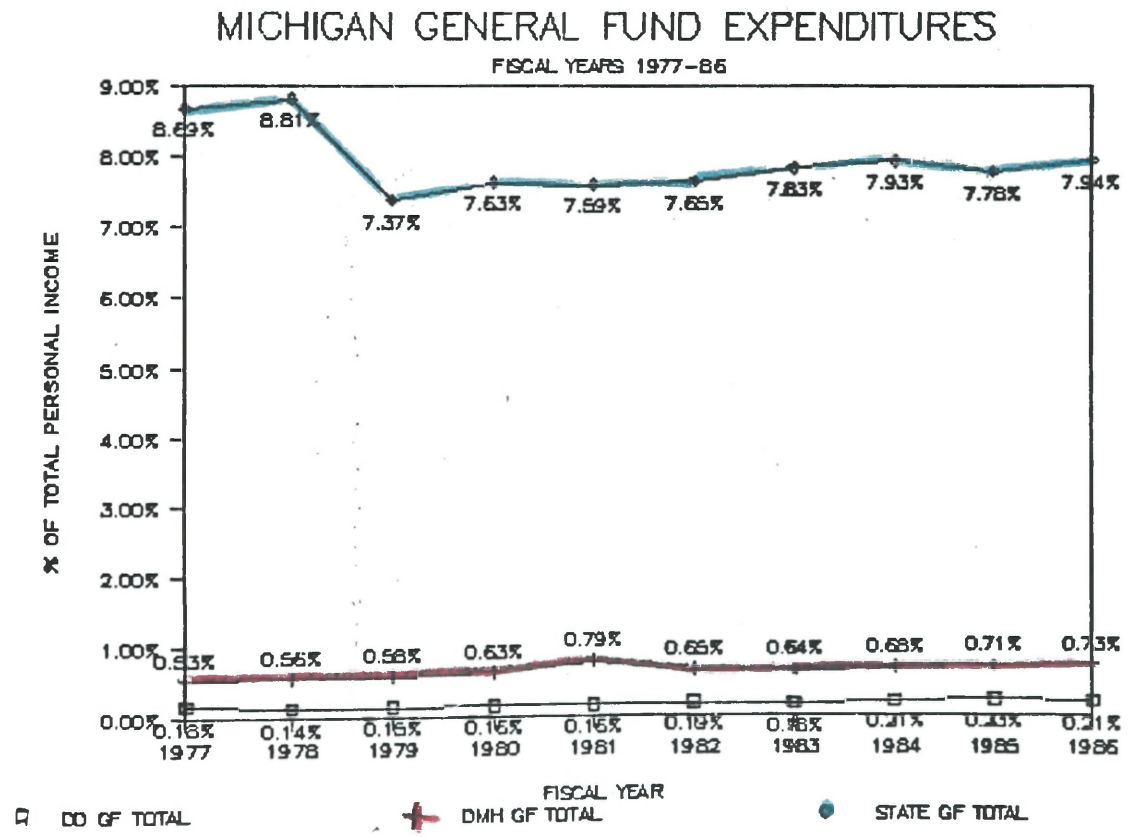
Graph #12 shows that the state's percentage of personal income for the total general fund expenses dropped sharply after 1978 and has remained lower since that time. The DMH and DD statistics are comparable to their actual expenses cited above.

Graphs #13 and #14 demonstrate that after 1978 the

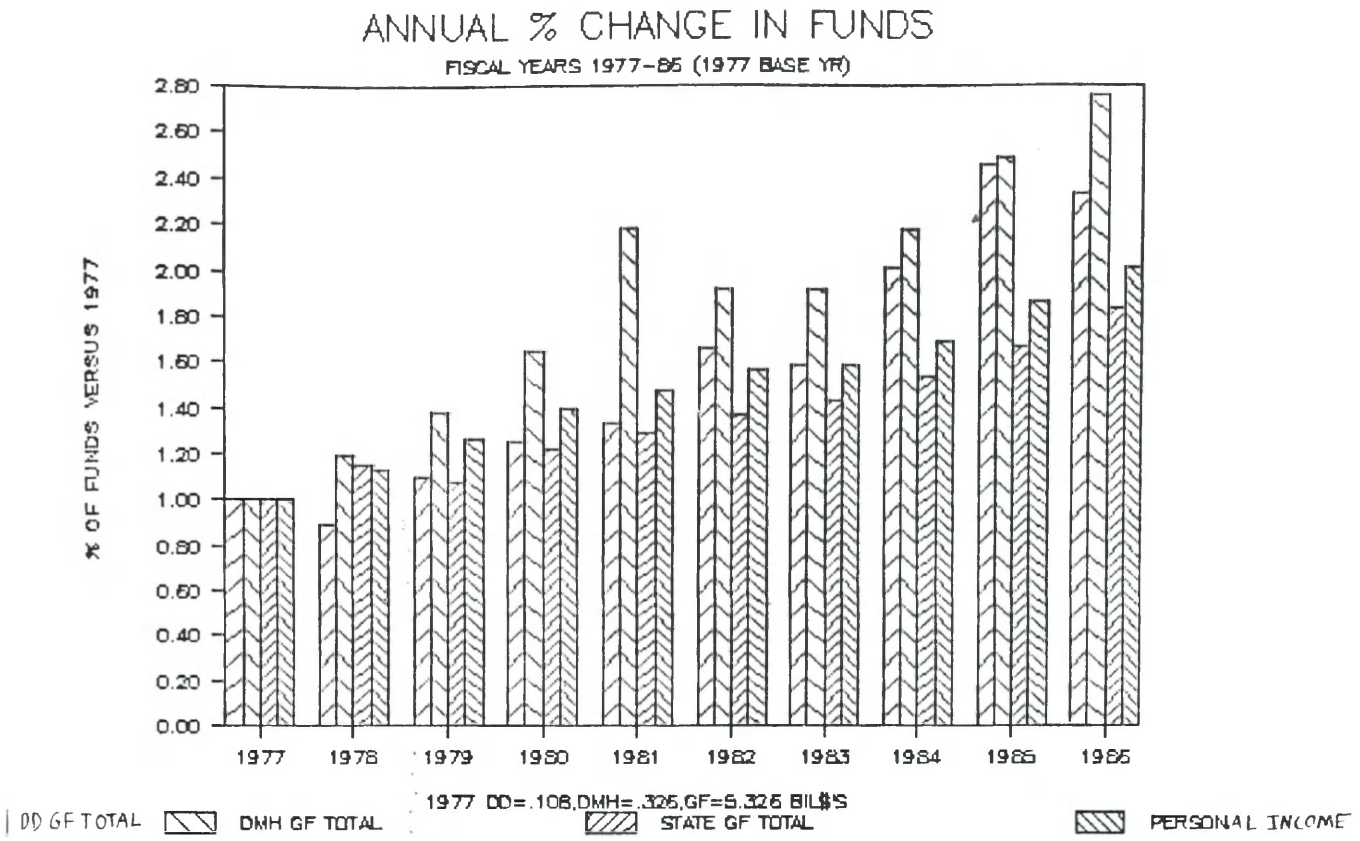
Graph #11



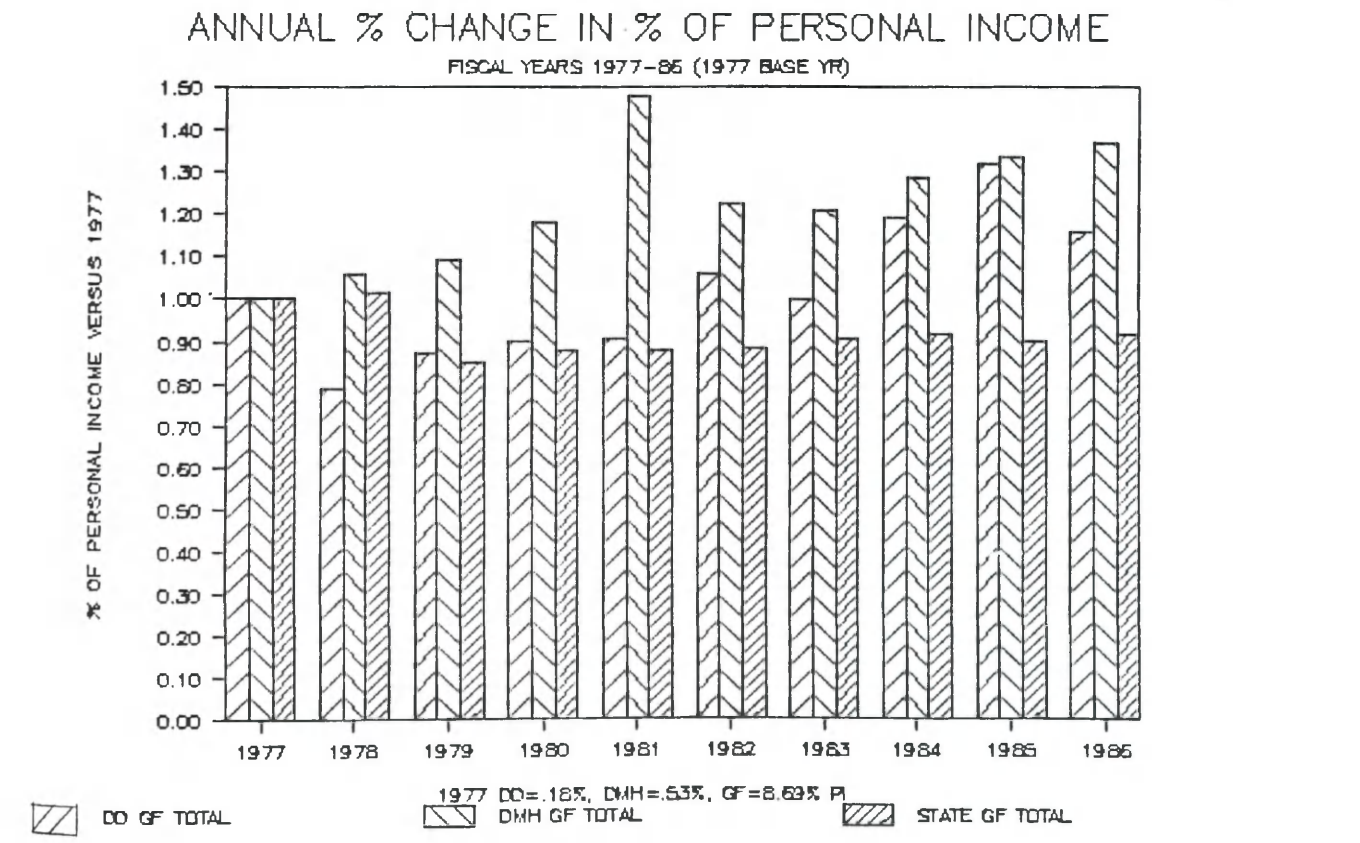
Graph #12



Graph #13



Graph #14

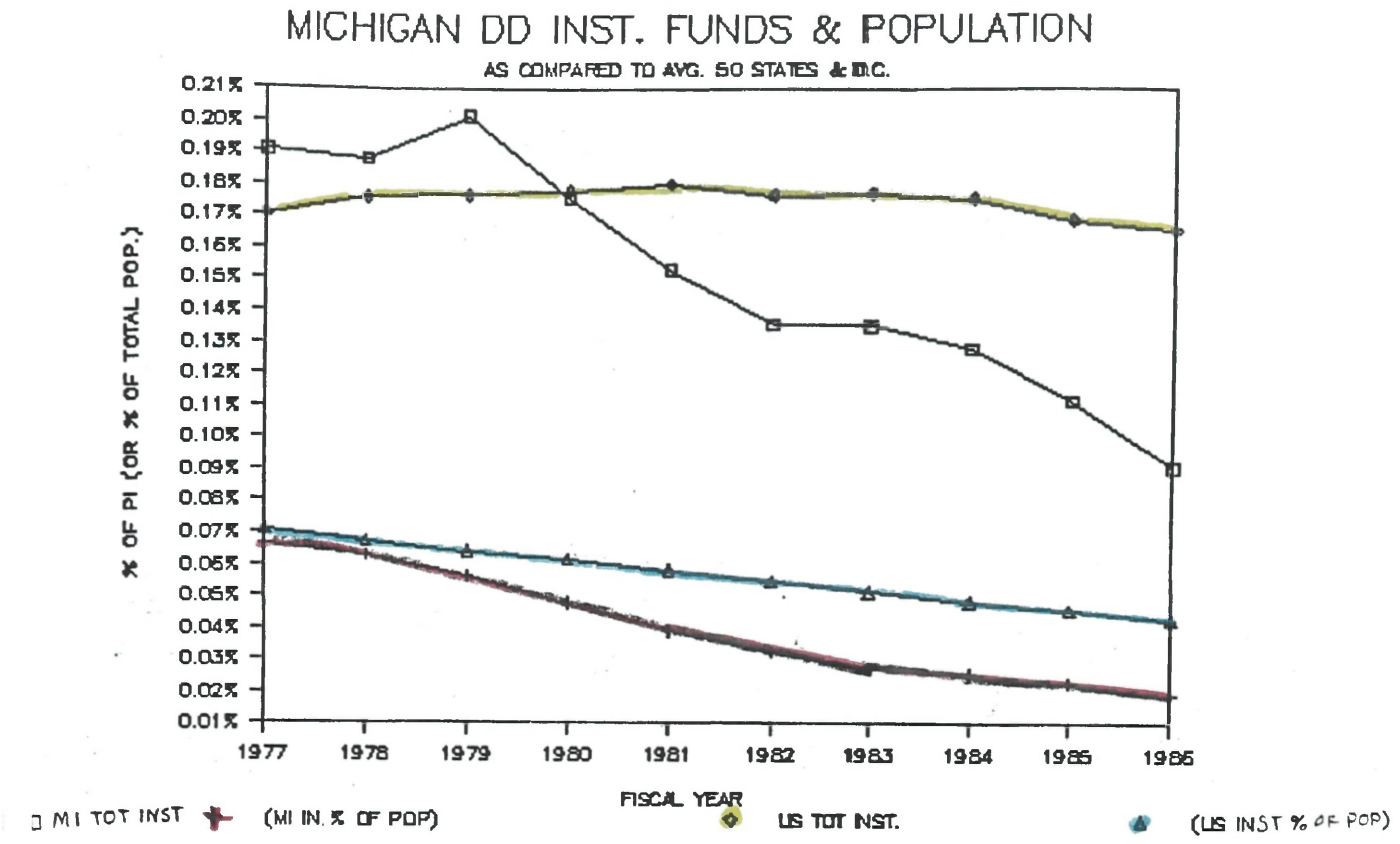


Michigan DD general fund expenses and the DMH total general revenue fund expenses have increased far beyond other state programs and also beyond the increase in the total personal income. The DMH program has consistently increased even more than the sub-category of DD expenses. In fact DD expenses increased their share of the pie from 2.04% (1977)to 2.56% (1986) or 27%, while DMH total expenses increased their share from 6.14% to 9.20% or 50% during the same period. Therefore each of these programs are receiving a much larger share of the state general fund budget. However, the total state general fund budget is not keeping up with the increase in Michigan's personal income. Later we'll examine whether this higher level of state funding for this program can be attributed to the shift to community services.

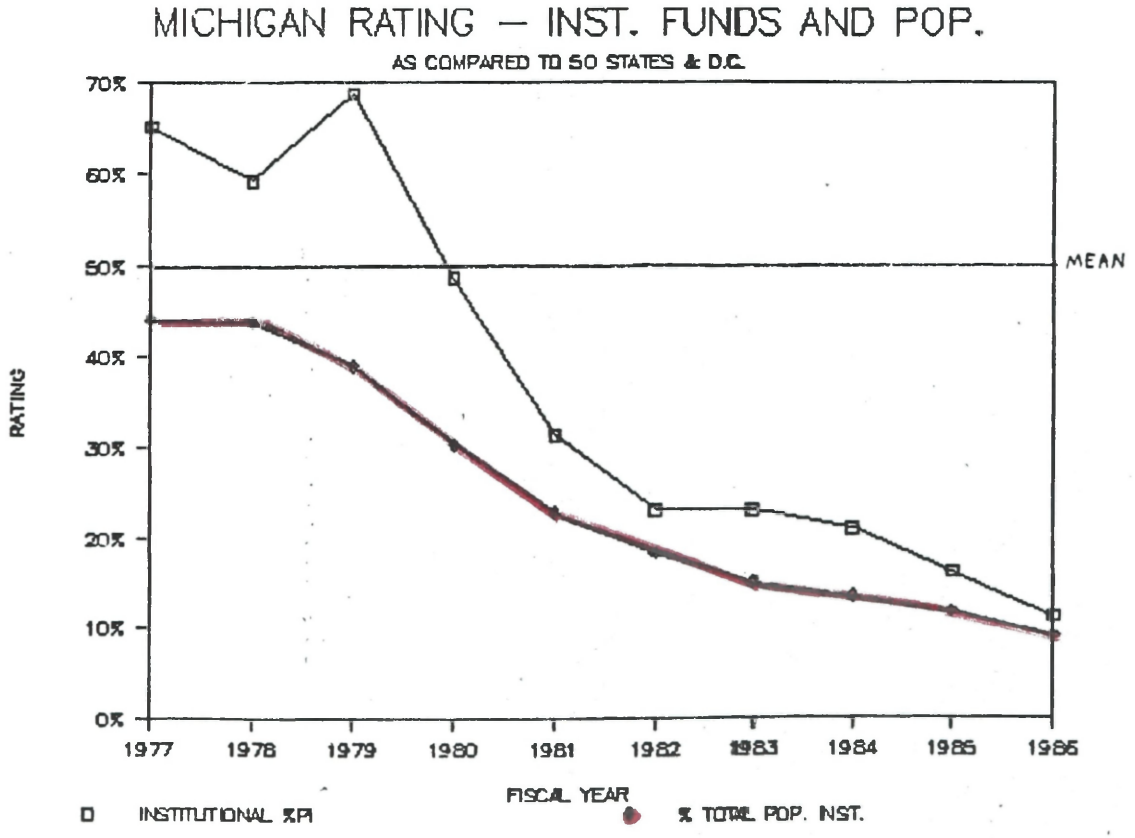
Total Institutional Funding and Services (Graphs #15-#20)

Graph #15 demonstrates that the total institutional expenses for persons with developmental disabilities dropped below the national average in 1980 and continued to drop thereafter except in 1983, when there was a slight leveling off period. The institutionalized population rate began the period below the national average. Indicating that Michigan was spending more of their share of total personal income then the average to serve a smaller % of total population in institutional settings. Later in the period, the percentage of persons living in institutions dropped sharply.

Graph #15



Graph #16



Graph #16 parallels graph #15 other than clearly presenting the dramatic variation between Michigan's institutional funding/services and the national average, which existed from approximately 1983 to 1986.

These findings support the second assumption that there will be a dramatic difference between Michigan's institutional funding and services as compared to the mean which should be higher during the period sometime after 1981.

The gap between Michigan's institutional funding and corresponding services, as compared to other states, seems to have decreased during the period. Institutional funding seems to have decreased more abruptly at times while the decrease in the institutional population seems to have been more gradual. This variance may be the result of closing costly institutions which no longer enjoy the economies of scale present when larger numbers of persons resided there.

It would seem that institutional expenses should be dependent upon the institutional population. To examine expenses without also considering the population factor could easily result in an inaccurate analysis of a state's efforts. This relationship was analyzed more completely in the next four graphs.

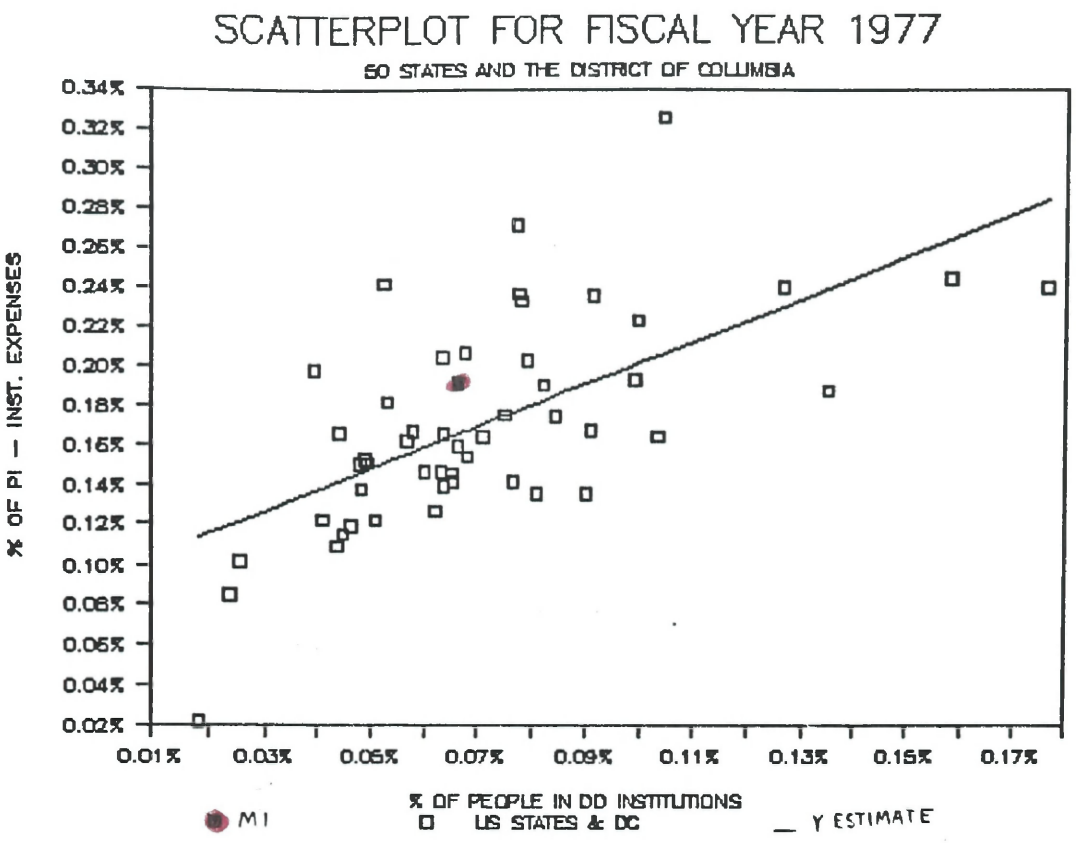
Graph #17 - This scatterplot depicts all states total institutional expenses (% of total personal income) versus institutional population (% of total population) for fiscal year 1977. Graph #18 shows the same relationship for fiscal year 1986. The resulting linear regression lines for each year demonstrates Michigan's position in relation to the estimate. In 1977, Michigan expenses were above the estimate, while in 1986 they fell below. The statistical data for these estimates are as follows:

Table of Institutional Linear Regression Data

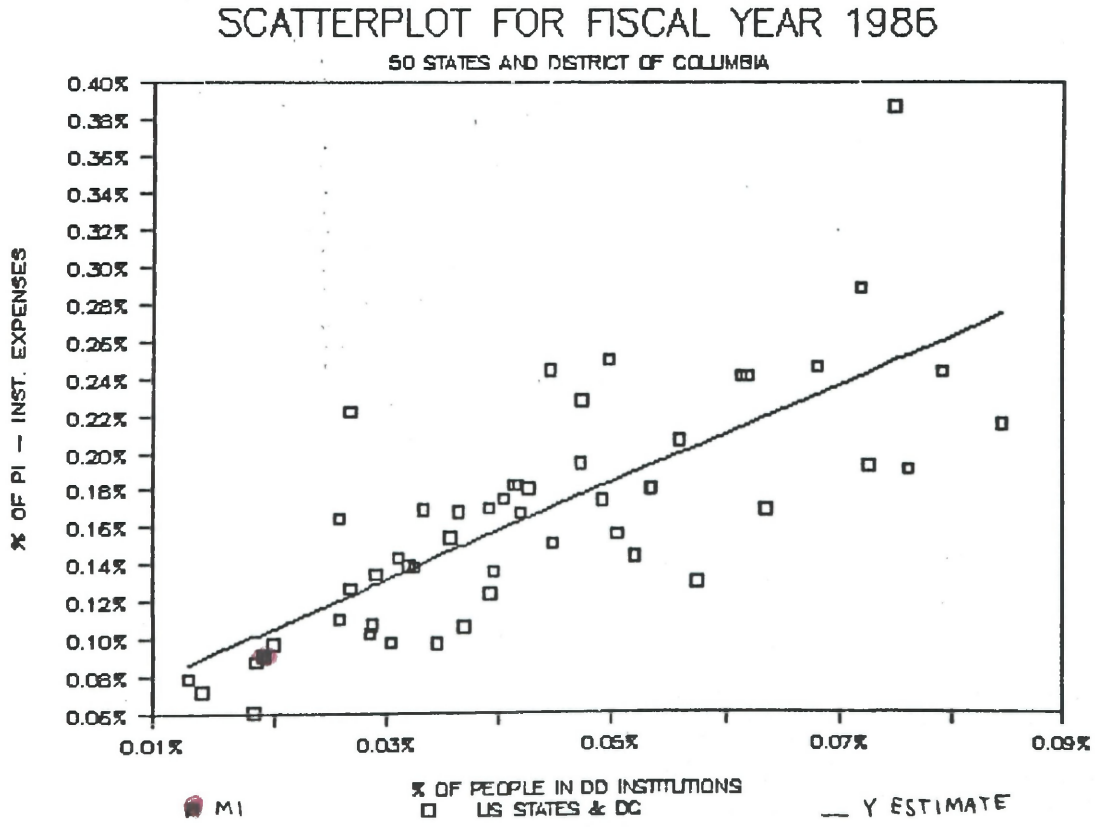
	1977	1986
Constant	.0009	.0005
Std Err of Y Est	.0004	.0004
R Squared	.4089	.5705
Adj. R Squared	.3968	.5617
# of Observations	51	51
Degrees of Freedom	49	49
X Coefficient	1.0847	2.6133
Std Err of Coef.	.1863	.3239
Student's t	4.430	5.233
Signif. (2 tail) p <	.01	.01

It appears as though the population factor is a much greater explanatory variable 56.17% in year 1986 as compared to 39.68% in year 1977. This may be due to increased federal

Graph #17



Graph #18



regulations which resulted in more standardized services and costs throughout the country.

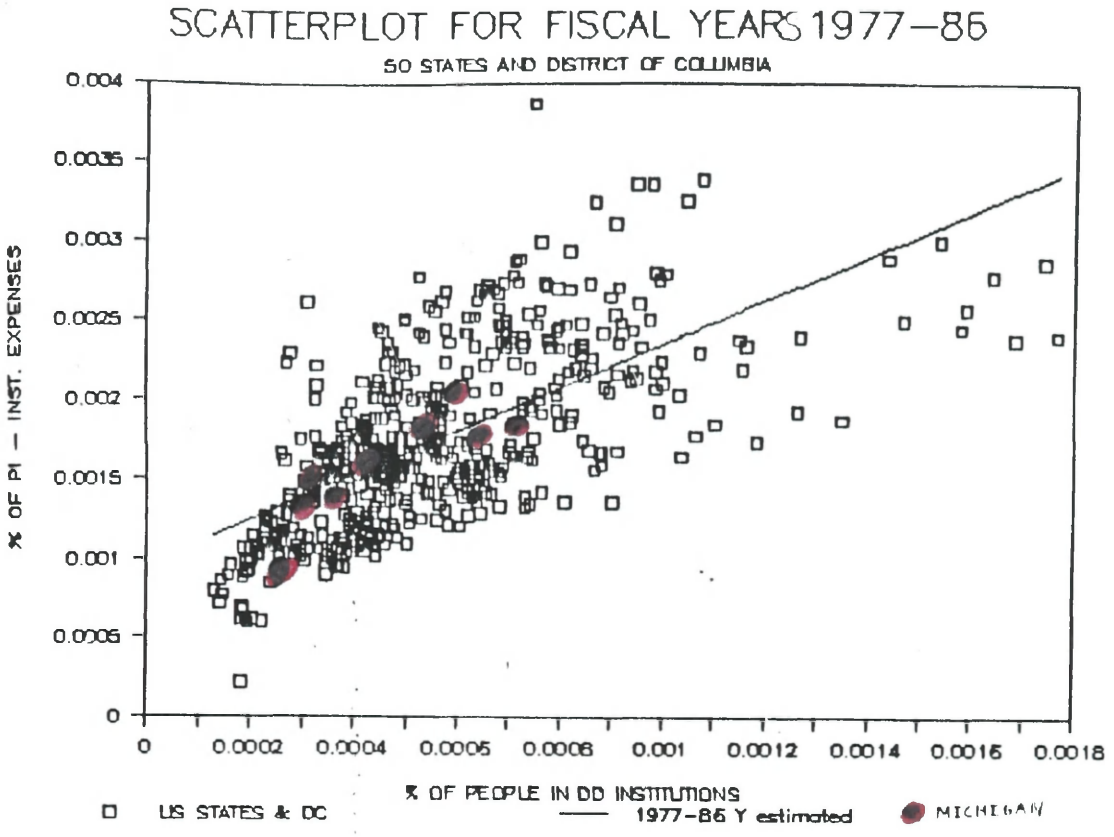
Graph #19 shows the entire scatterplot for fiscal years 1977 to 1986. A regression line was estimated but only to be used as a crude reference point since there are obvious autocorrelation problems with conducting estimates by pooling time series data. The Michigan plotted points show the steady progression of deinstitutionalization with fiscal year 1986 being the farthest to the right and each consecutive year moving one point closer to the left corresponding to lower institutional populations.

There is some question about how reliable the estimate equations are for those states with an institutionalized population of .02% or less since there are many points which fall below the line for this subset. There may different and more cost efficient economies for these particular points.

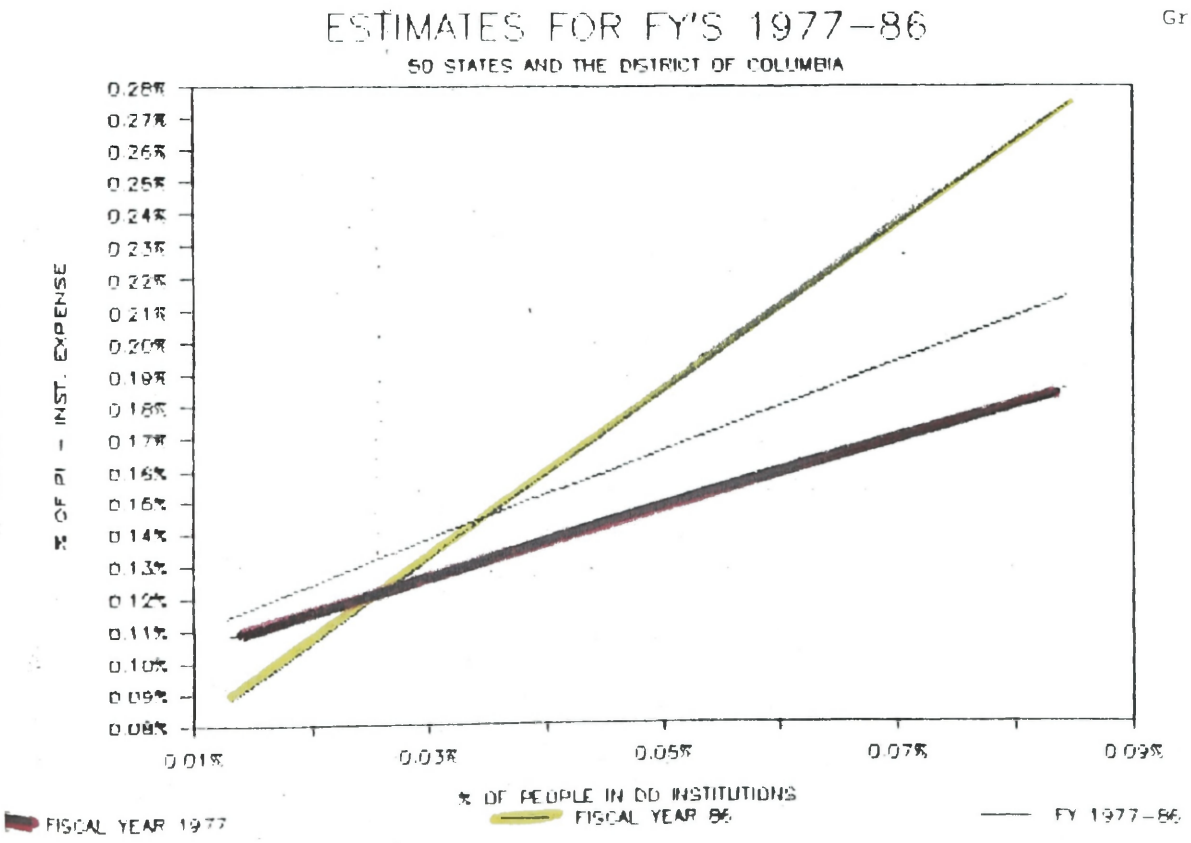
Graph #20 demonstrates the upward shifting estimate from years 1977 to 1986. These greater costs are likely to be the result of increased federal regulations associated with the ICF/MR program. It is expected that the incline would have increased with each individual consecutive year however this was not completely examined as a part of this study.

Michigan's institutional services and funding has never

Graph #19



Graph #20



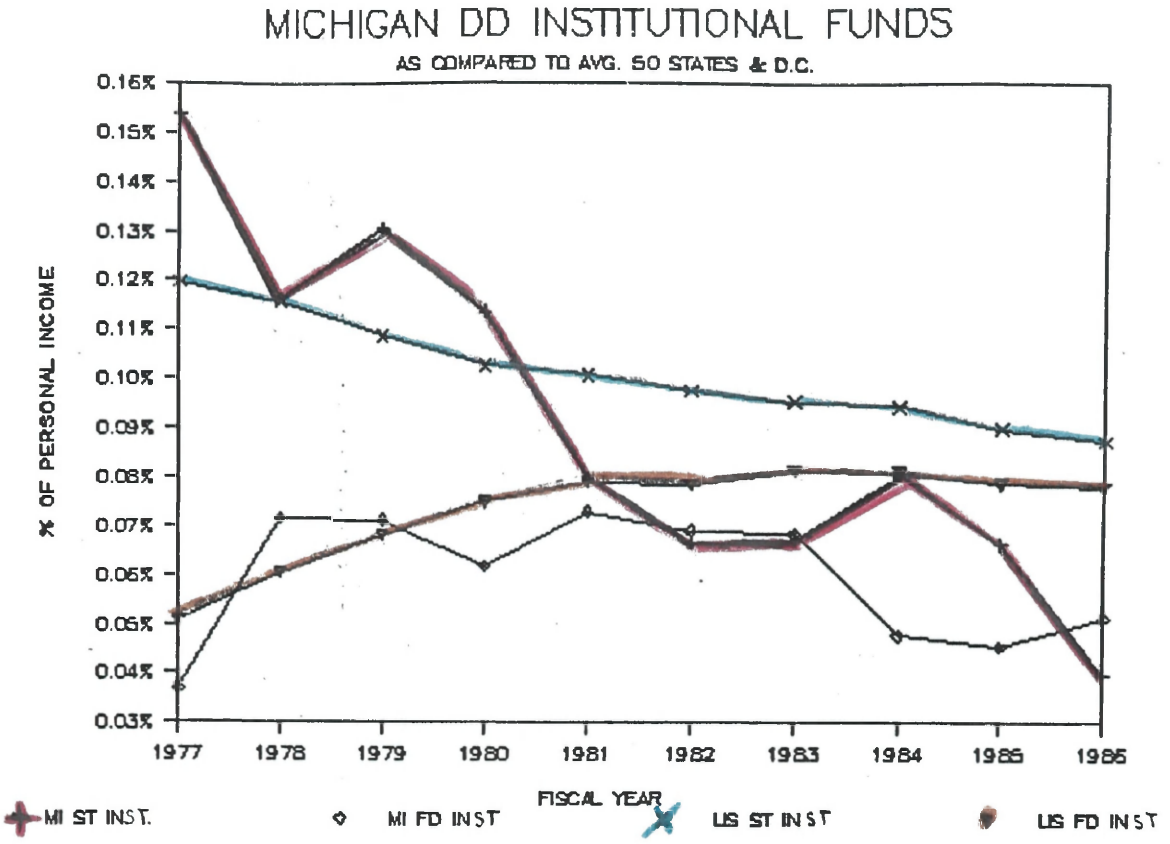
deviated extensively from the overall estimate. Nor has the state had comparatively large numbers of persons institutionalized as compared to other states. The deinstitutionalization efforts initiated in Michigan do not appear to be the result of comparative national statistics but more the result of increased local expectations.

Federal and State Institutional Funding (Graphs #21-#22)

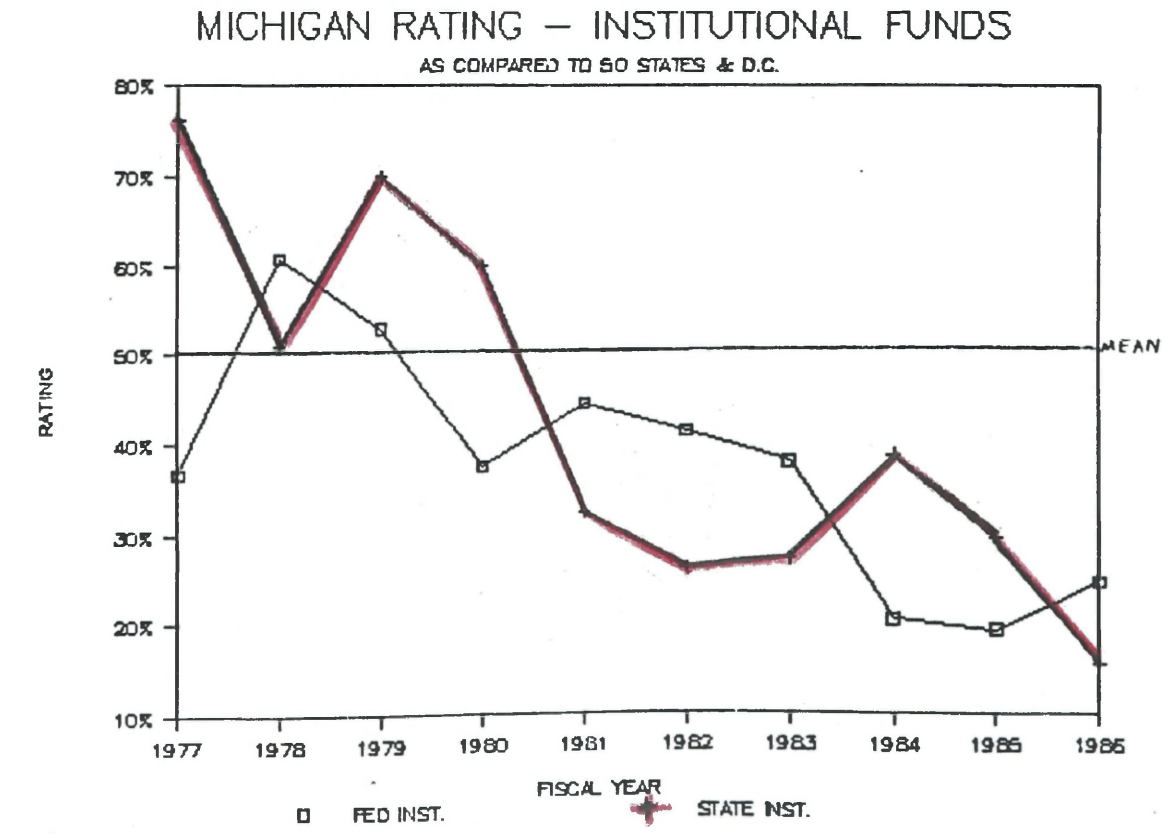
Graph #21 demonstrates the distribution of federal and state institutional funding for Michigan and the average of all states. Usually state funds have been used primarily to support these settings however in fiscal years 1982, 1983 and 1986, the federal funding exceeded the state funding of these services in Michigan. The U.S. average never showed greater federal versus state funding, but it does show a narrowing of the variation between the two during this period. This graph also verifies Braddock's findings of a negative correlation between state and federal institutional funding for both the national and Michigan data.

Graph #22 shows that the only dramatic difference between Michigan's institutional funding distribution and the mean occurred in 1986. Furthermore for half of the years the rating of federal institutional expenses received by Michigan exceeded the state institutional expense rating. This leads

Graph #21



Graph #22



us to believe that the high total state expenditures noted in Graphs #9-#10 may be more attributable to community rather than institutional expenses.

Community Funding Total/Federal/State (Graphs #23-#26)

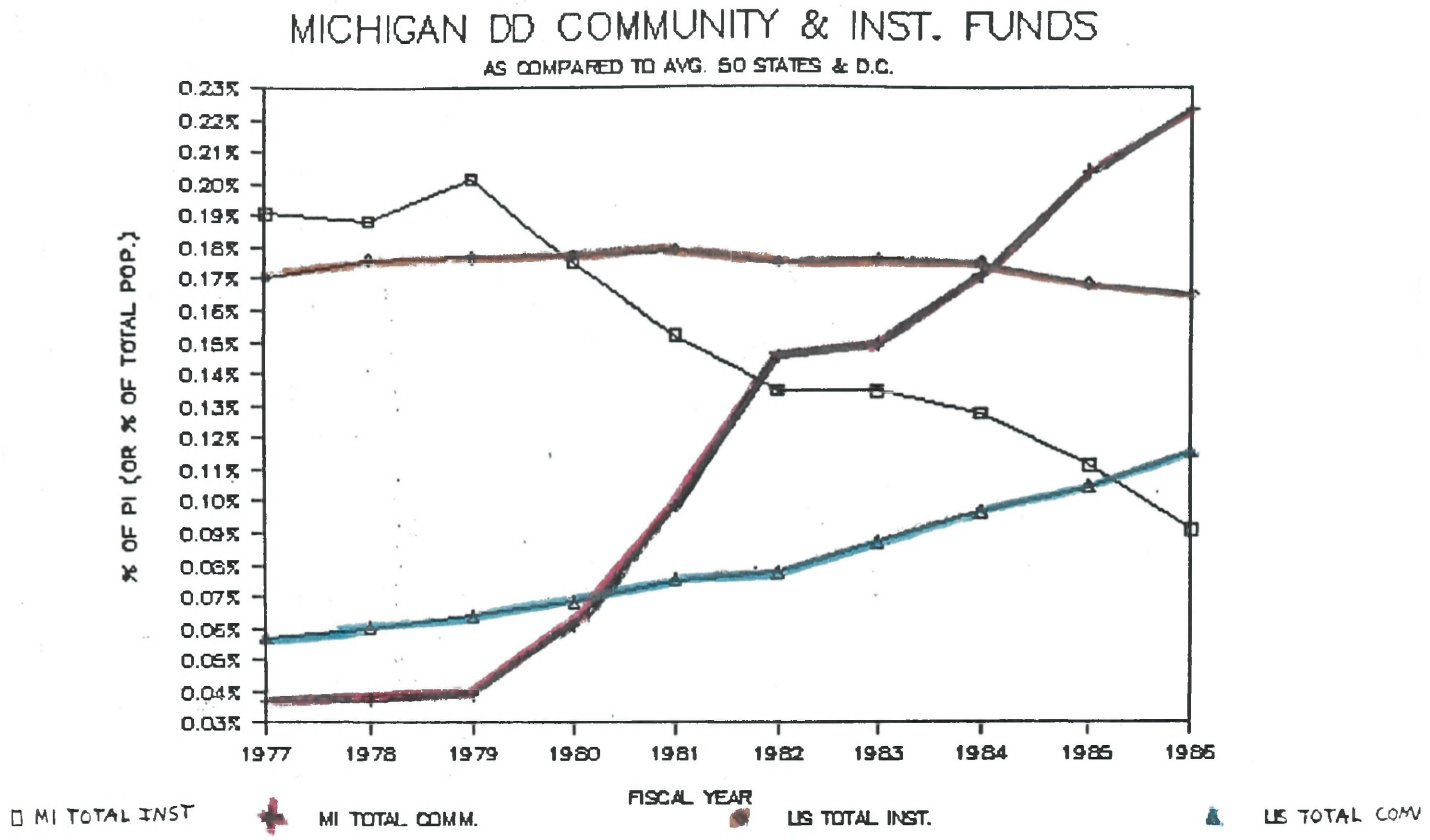
Graph #23 shows the community expenditures compared to institutional expenditures. While the average U.S. community expenses did not exceeded the institutional expenses, Michigan's community expenses did from 1982 to 1986.

Graph #24 portrays the dramatic variation between the mean and Michigan's community expenditures beginning in 1982 and continuing throughout the period. This verifies the assumption cited earlier with respect to a dramatic variation after 1982. This level was much more extensive than what was found in the institutional rating throughout the period.

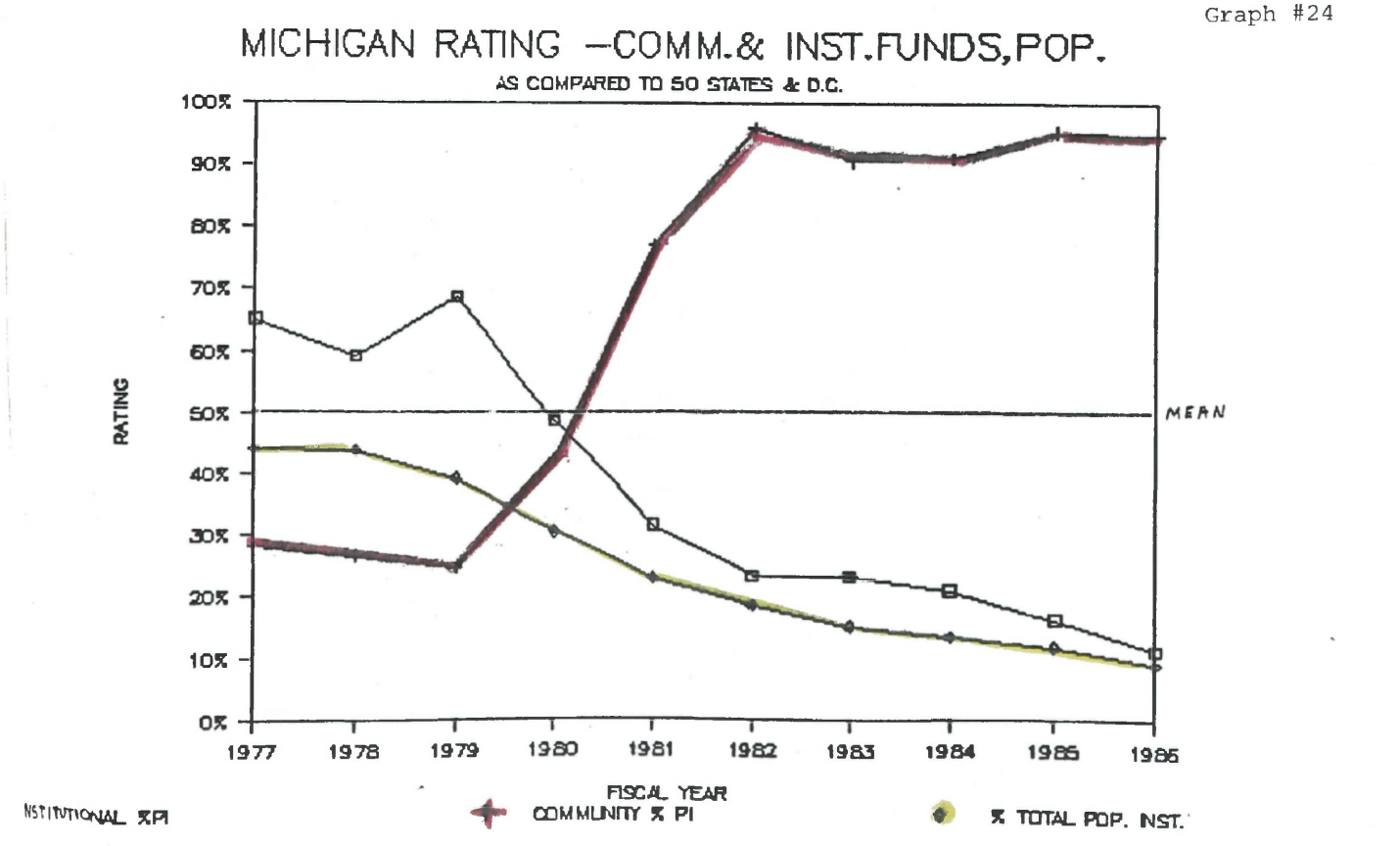
Graph #25 depicts the distribution of federal and state community services funding during the period. Michigan's higher community expenditures are clearly the result of a state fiscal effort since the federal funds were much less than the mean for the majority of the years studied.

Graph #26 shows that federal funding for community services in Michigan were dramatically less than the mean for years 1977 to 1980 and had increased closer to the mean after

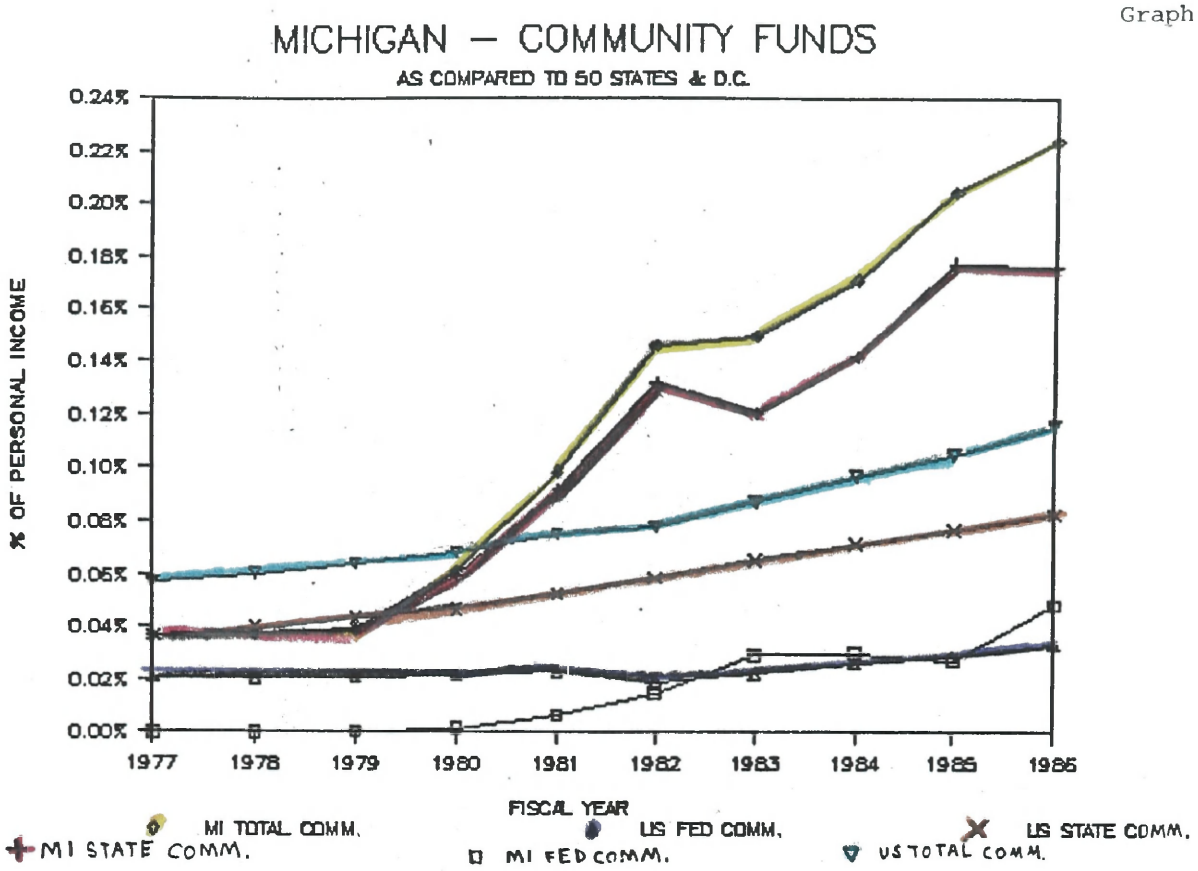
Graph #23



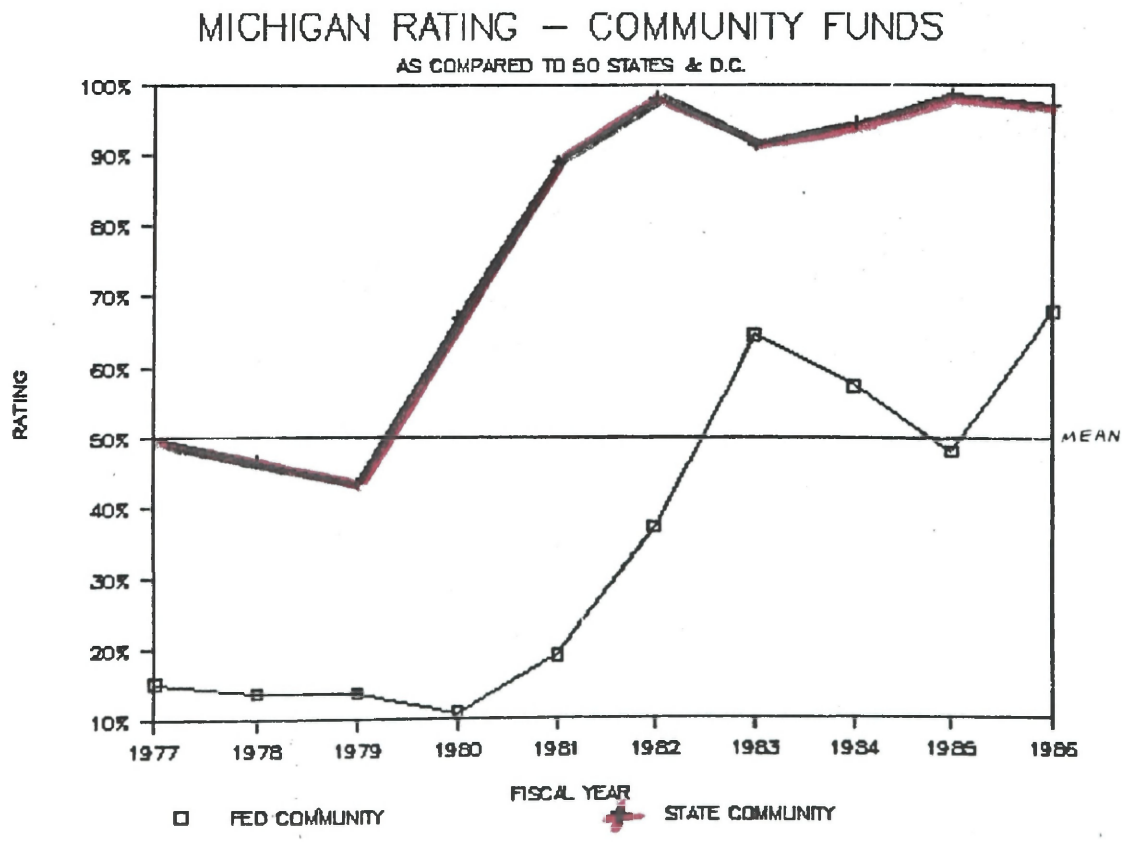
Graph #24



Graph #25



Graph #26



that time. State community expenditures were rated dramatically higher than the mean beginning in 1981 and remained there throughout 1986.

Primary utilization of state funding for community services has clearly resulted in higher total state DD expenditures in Michigan as compared to the national average. An extensive expansion of non-federally reimbursed community based residential services would have produced this particular effect. This situation was noted in the Pennhurst cost comparison study (Jones et al, 1986) which was discussed in Section III of this paper. The next section of this paper solely examines Michigan's community funding and services effort.

Michigan Community Funding and Services (Graphs #27-#32)

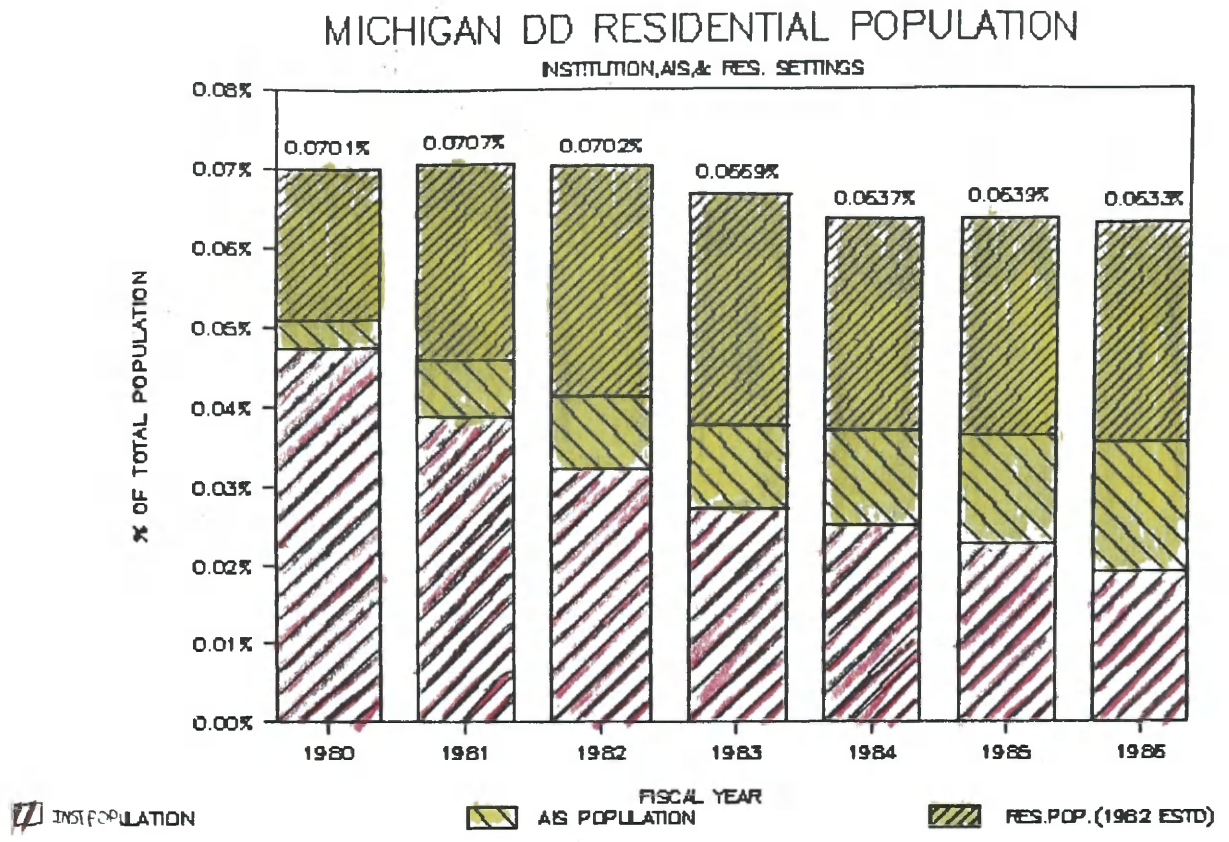
When people are moved from institutional to community settings they are often more difficult to track for research purposes. The less regulated a setting is, the less likely that one will find statistical data. Community settings are often less structured and regulated than institutional settings. Detailed community service data was not readily available for the total states or Michigan. Most of the information presented in the following graphs was provided by the Michigan Department of Mental Health or Braddock's 1986 data. There are some problems with combining data of this

type from different sources. I checked several comparative points and identified an error of plus or minus two percent. I believe this to be fair estimate the average extent of this problem.

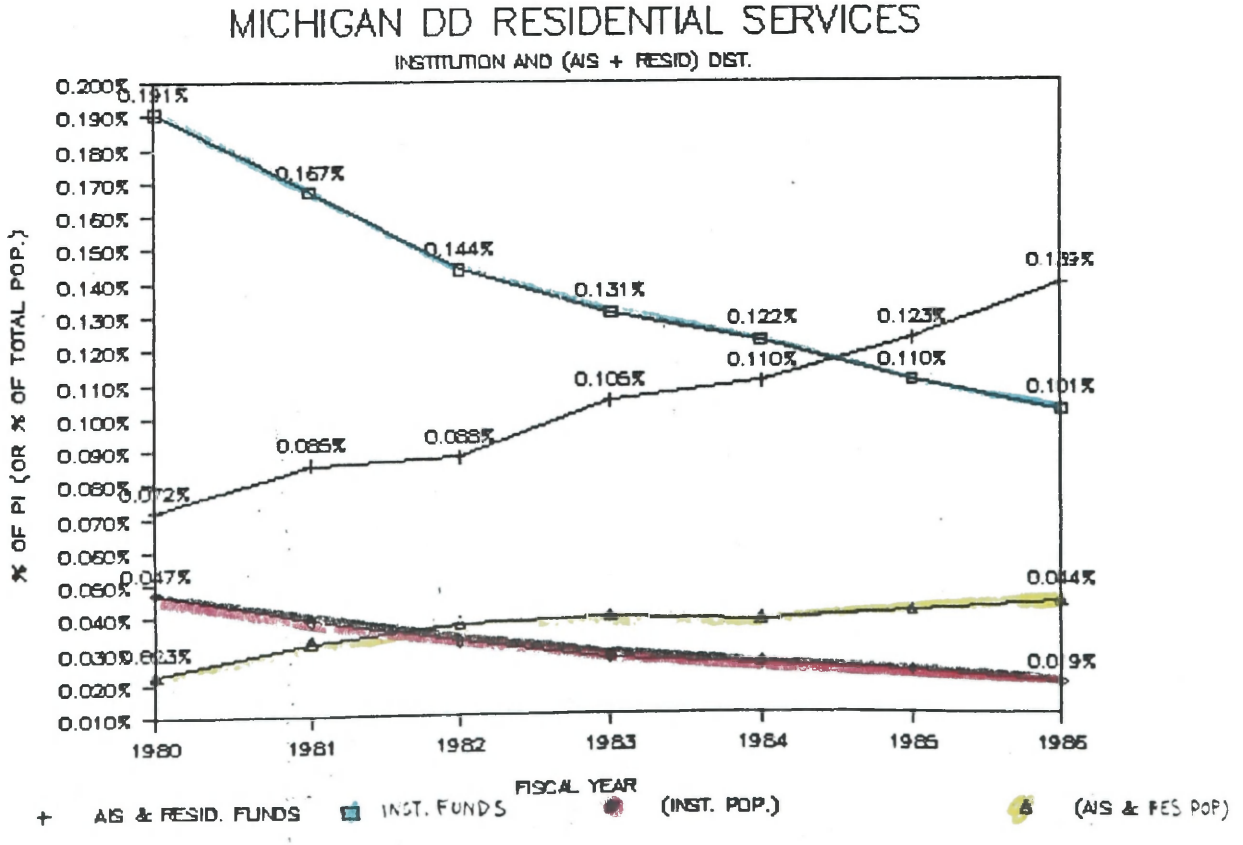
Graph #27 included information only for fiscal years 1980 through 1986 since these were the only consecutive years for which information was available. There are three types of residential settings noted in this graph. They include institutional settings, AIS/MR (small community based ICF/MR's) and other state residential services. The latter category is almost entirely state funded. The annual census for other residential services was not available and had to be calculated from total program costs divided by the cost per person per day. These data were not available for 1982 and had to be estimated for the other residential services group. During this period it is clear that these non-federally funded settings have continued to be the largest setting serving the majority of persons who were deinstitutionalized. However, AIS/MR settings have expanded their share significantly during this period. Institutional placements, on the other hand, have decreased by approximately 50% during this period.

The extensive use of other residential services appears to be the key factor which has led to substantially higher total state mental health DD service expenses in Michigan as

Graph #27



Graph #28



compared to other states. It is unclear to what degree mental health administrators could have shifted their focus towards small community based ICF/MR's (AIS Homes) sooner than what they had. Perhaps a more gradual deinstitutionalization effort would have meant lower state expenses in the long run. However there were obvious legal and value based issues involved in this shifting of services which contributed to these decisions.

The total number of persons served in these state coordinated settings has also decreased by approximately 10% during this period. It is unclear whether local efforts by community mental health boards are included in the other residential services. If it this not included, then the corresponding total may not have decreased this much.

Graph #28 demonstrates the relationship between institutional and community based residential funding and service populations. Unlike graph #23, the community services component here does not include non-residential related items such as community based day treatment programs. It was not until 1985 that the funding for community based services exceeded institutional funding, while the population for community based residential services surpassed the institutional population in 1982. The costs of serving those persons remaining in institutions is clearly much higher than general costs for community residential services.

Graphs #29 and #30 show the total institutional funding decreased from 61.3% of the total mental health DD expenses in 1980 to only 24.1% of those expenses in 1986. There has been a sharp funding increase in each of the other settings especially with FIM payments, which primarily support people in non-ICF settings.

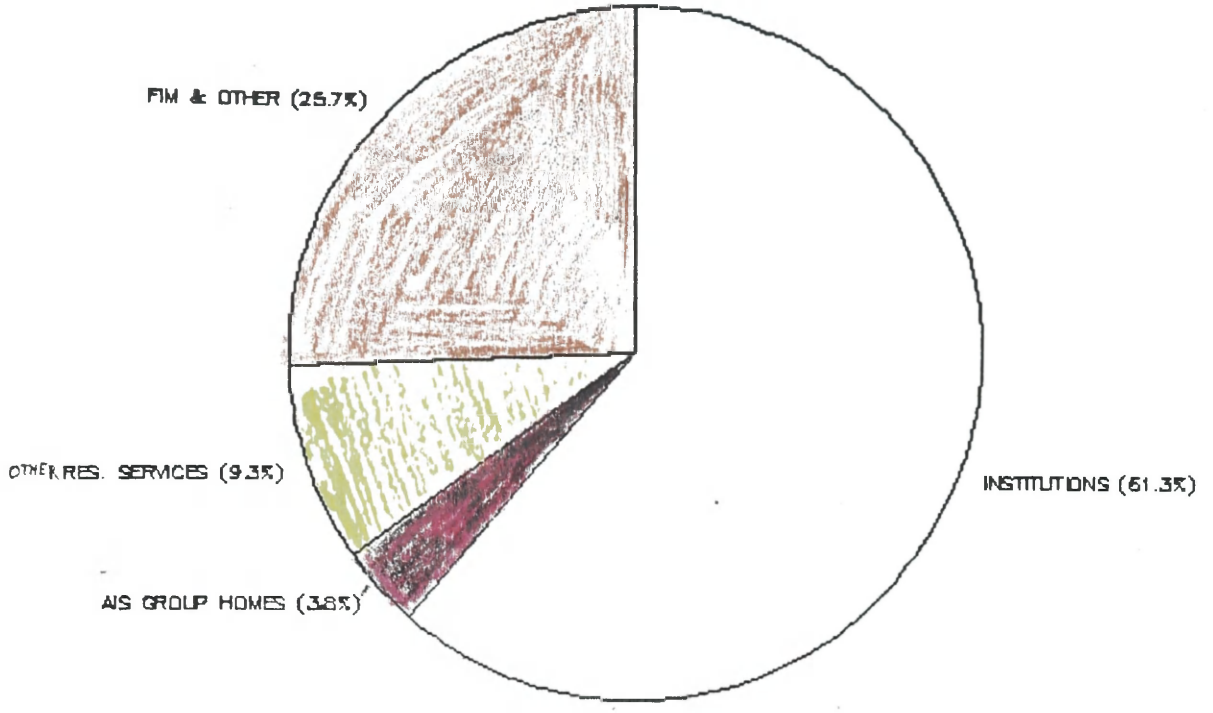
Graphs #31 and #32 demonstrate that the shift in the numbers of people served by state coordinated programs has not changed significantly. However there has been an observable shift from institutional to other state coordinated community residential services (AIS and other residential services). It does not appear as though there has been an expansion of additional residential services to persons presently residing in the community. A very conservative estimate was utilized to identify the population who only receive FIM payments. This amount does not reflect the residential service needs for persons who are living with relatives and not receiving SSI or SSDI payments.

The final part of the my third assumption which stated that community services would expand primarily to serve the deinstitutionalized population, appears to be true. This assumption was based upon the belief that limited resources which are committed to development of deinstitutionalized settings, according to the Plymouth consent decree, would in

Graph #29

MICHIGAN DD EXPENDITURES FISCAL YR 1980

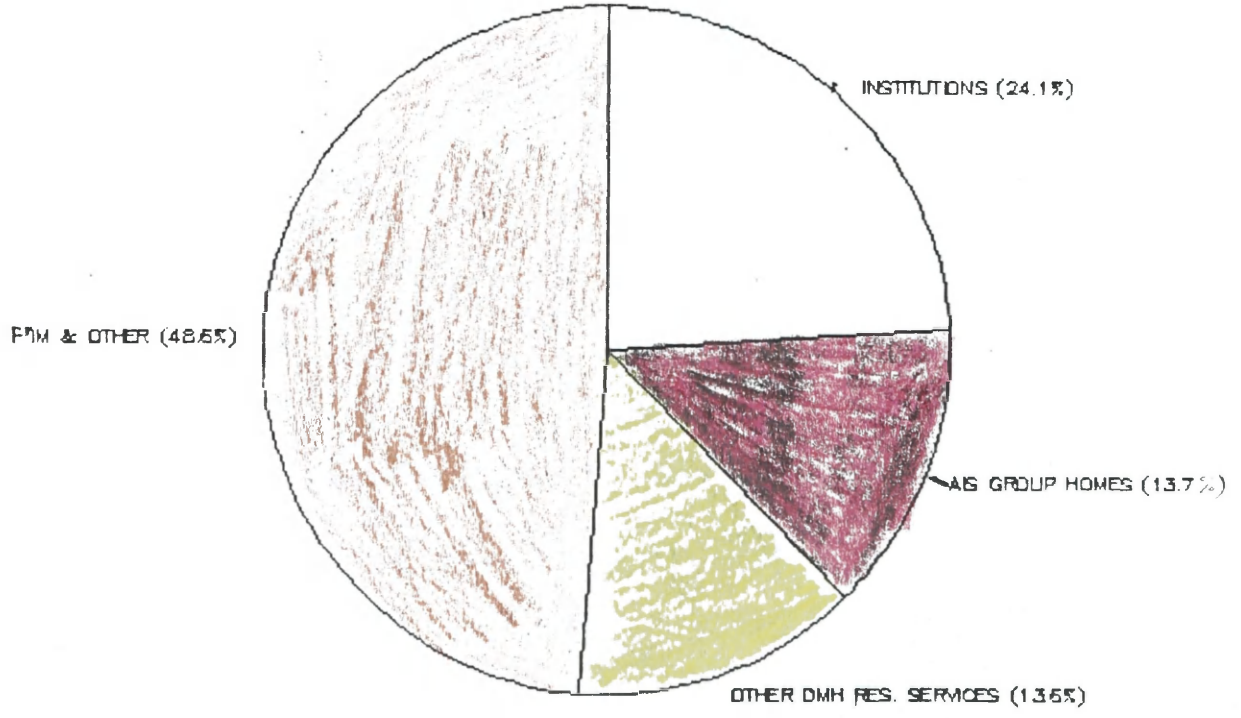
TOTAL = $266,133,000 (ERROR = +/- 2%)



Graph #30

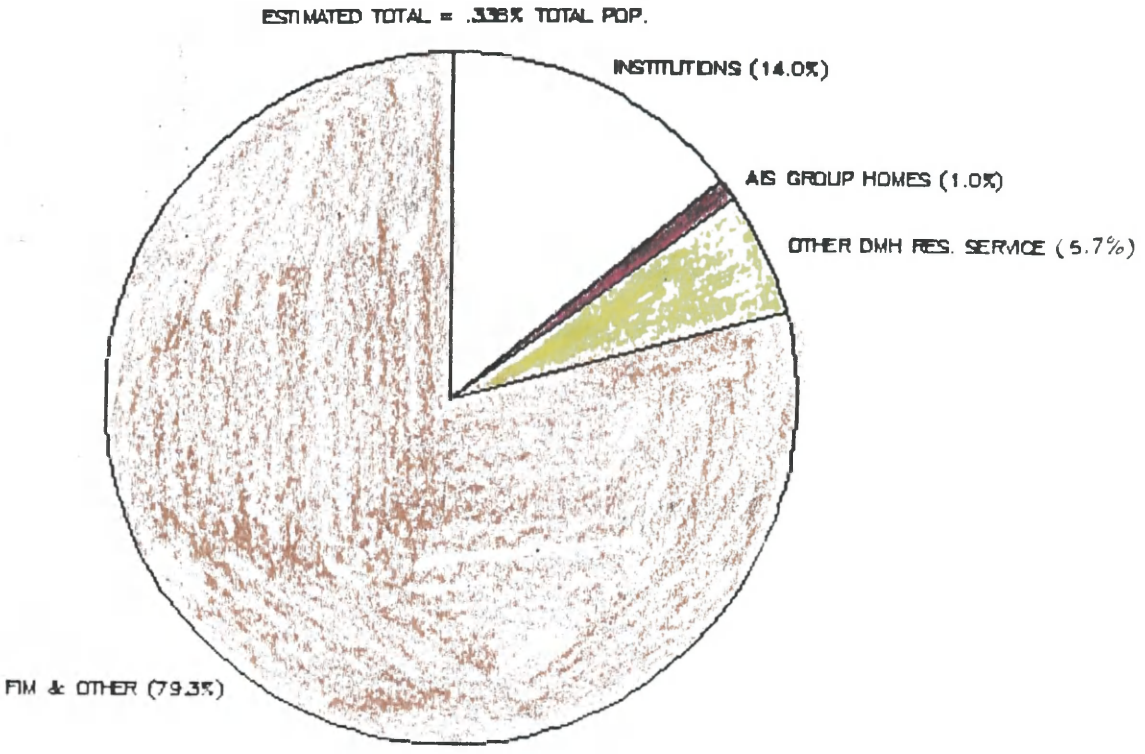
MICHIGAN DD EXPENDITURES FISCAL YR 1986

TOTAL = $620,844,200 (ERROR = +/- 2%)



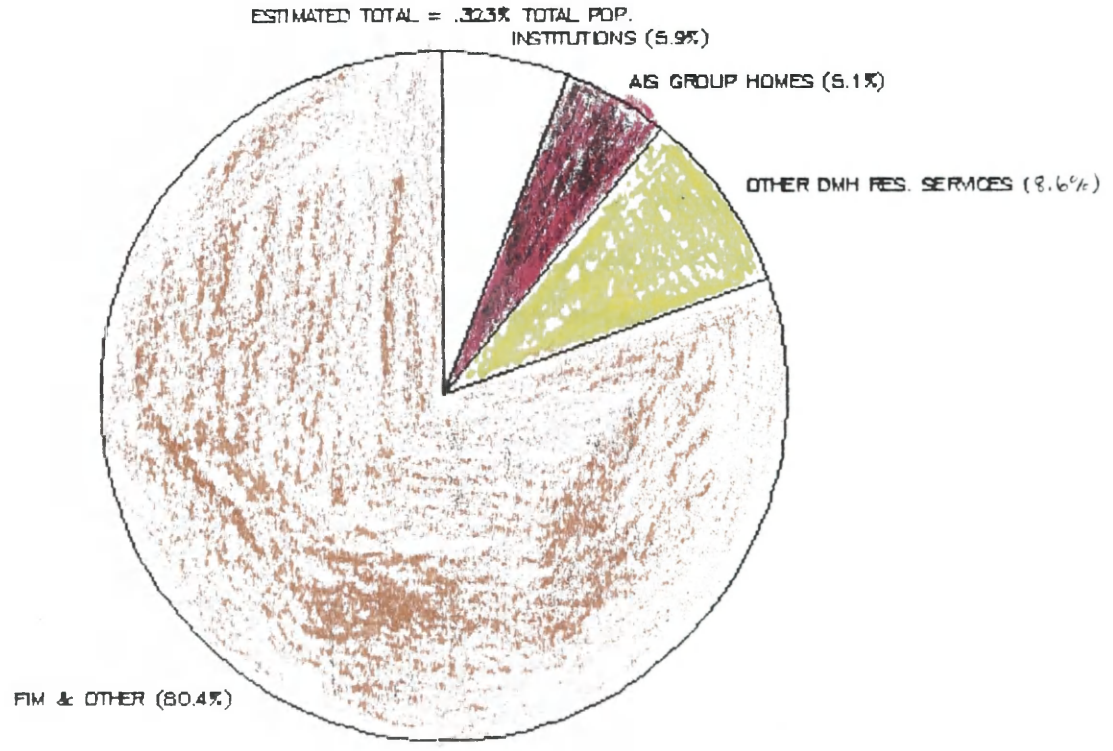
Graph #31

MICHIGAN DD POPULATION — FISCAL YR 1980



Graph #32

MICHIGAN DD POPULATION — FISCAL YR 1986



fact be primarily directed to that goal, as opposed to expanding services for persons presently residing in the community. Institutionalized and deinstitutionalized persons during the period studied have clearly had the top priority for accessing new services and substantial funding. The overall percentage covered in these three settings has not changed significantly, although there have been tremendous shifting in between the three state coordinated categories (excluding FIM).

A examination of the shifting of services from institutional to community based services was conducted and reported in this section. Several assumptions regarding Michigan's dramatic variance from other states efforts with respect to their deinstitutionalization and community services expansion efforts were found to be accurate. An unexpected emphasis on state funding was noted and analyzed in greater detail. A more complete study of community services and funding for all states appears to be clearly warranted but is beyond the scope of this research. These issues will be addressed more completely in Section VI of this paper.

VI. Summary/Conclusions

The original intent of this research was to provide a comprehensive comparative analysis of Michigan's transition from institutional to community based services for persons with developmental disabilities versus similar changes in other states. Furthermore, it was expected that the methods utilized herein could be generalized to provide a useful model for future studies.

The examination of the historical events which have prompted a fifty percent reduction in the national institutional population during the last two decades revealed a multi-faceted picture. Changes in terminology, public awareness, advocacy, litigation and public funding have been the primary factors prompting this transition.

Michigan's experience with these factors has been more progressive than what has occurred in most other states. The early advocacy efforts by the ARC of Michigan were instrumental in prompting changes which occurred many years before similar changes in other states. This is especially apparent with P.A. 198 and the Plymouth Decree. Mental health administrators were also innovative with their efforts and commitment to establishing small community based ICFMR's and proposing the closure of 4 institutions in addition to the Plymouth Center. Only five state legislatures had

amended their zoning laws to address the issue of group home development before Michigan did. The entire state judicial system in Michigan has supported this law allowing the state legislature to supersede local zoning ordinances. These factors create a combined network of advocates, public administrators, legislators, and justices all of whom were committed to innovative changes in Michigan.

This network of supporters was not common in most other states. The empirical literature which was reviewed provided some answers as to why this happened in Michigan. Hudson's study suggested that Michigan's demographics, type of taxation and governor's power to appoint the mental health director, would have a positive impact on mental health spending levels. Sigelman et al., (1981) and Braddock et al., (1987) also suggested other factors which indicate, after a cursory review, Michigan would rate highly on with respect to deinstitutionalization efforts. The review of major court orders and consent decrees demonstrated that those actions stipulating institutional depopulation, like the Plymouth decree, were associated with higher community spending rankings. Further statistical research is still warranted in this area however, I believe that the results will show that this was the key explanatory variable in Michigan's dramatic transitional efforts in this area.

I would agree that during normal economic times the

demographic and political considerations cited throughout the literature would be key factors. However this was not a normal time for Michigan. Michigan's general economic climate differed dramatically from the average of the states, and placed that state near economic depression.

Additional findings of this study provided specific information on the degree to which Michigan differed from the average state in expenditures and services. Michigan's total mental health expenditures were shown to be slightly higher than mean since the decree was enacted. This was expected given the level of support which was already noted. However, what I didn't anticipate was the degree to which Michigan was financing these expenditures with a greater portion of state general revenue monies than other states utilized, and a much lower amount of federal funds than other states used.

An initial examination of the data revealed that Michigan's institutional expenses were dramatically lower than other states and community expenses were dramatically higher that other states. Braddock et al., (1986) had already performed this type of study but had not demonstrated the degree to which Michigan had deviated from the mean, which was more than 1 standard deviation for each of these types of funding. The question now was whether the higher total state DD expenses were attributed to the institutional or community based programs.

Further analysis revealed that the institutional expenditures were fairly consistent with the average state expenditures given the level of population served in that setting. This analysis was made utilizing linear regression and thereby demonstrating where Michigan fell in relation to the estimate. Additional data revealed that federal institutional expenses had exceeded state institutional expenses numerous times during the period studied. However, the portion of state funds utilized for community residences dramatically exceeded the national average while the federal portion was much closer to the average.

Unlike the inverse relationship between state and federal institutional expenses, both state and federal community expenses rose sharply in Michigan.

When Michigan's community residential services were scrutinized in greater detail it was determined that those non-federally reimbursed residential settings (other DMH residential services), which have been a primary placement for persons recently deinstitutionalized, are probably responsible for this greater burden on the state tax base. This same type of relationship was noted on a smaller scale study by Jones et al., (1984), of seventy persons deinstitutionalized in Pennsylvania.

These increased state costs have resulted in an increase of 27% in the share of the Michigan's state general fund budget which is devoted to mental health services for persons with developmental disabilities during the period studied.

In light of these findings I believe that the primary factor affecting Michigan's mental health expenditures has been the change in public opinion prompted by the Plymouth Decree. The timing of this litigation coupled with the dramatic shifting in services and funding levels are clearly associated. This may also explain the utilization of non-federally reimbursed community residential alternatives. The pressure from litigation had probably made this consideration more of a value based decision rather than one of pure economics.

What prompted the litigation is another issue. The State of Michigan had originally appointed the ARC of Michigan to provide state sponsored protection and advocacy services. When the ARC of Michigan pursued litigation against the state to force the closure of Plymouth, the state was receptive to a settlement. It is quite possible that both the advocate groups and some innovative public administrators utilized this process of litigation to support widespread changes in Michigan's mental health services for persons with developmental disabilities.

How Michigan rates presently in comparison to other states is somewhat unclear. This study was based on data which were approximately three years old, some of which were proposed expenditures as opposed to actual ones. Considering the degree to which Michigan's services changed during the three years from 1981 to 1984, it is apparent that funding and services can change dramatically in a limited period of time. Although, I believe that once a widespread commitment to community integration occurs, slowing the process of deinstitutionalization is not likely. This is because the number of advocates for the program increases dramatically every time a new person is placed into the community. Suddenly, value based considerations become even more important when these services occur openly in public settings rather than segregated settings. Public opinion appears to have outweighed some economic considerations with the program in the past.

Even if Michigan should continue its efforts the current trend is for other states to continue shifting towards community based services and they may chip away at the lead which Michigan has. Proposed changes in the federal funding of institutions could provide just the motivation that other states may need to close this gap between the average state's efforts and Michigan's. Updated information applied using this same model employed in this study, should provide the necessary answers some of these comparative questions.

Appendix A - Advocacy Groups

American Association of University Affiliated Programs
for Persons with Developmental Disabilities
8605 Cameron Street
Suite 406
Silver Spring, Maryland 20910
(301) 588-8252

Association for Persons with Severe Handicaps
(TASH)
7010 Roosevelt Way NE
Seattle, WA 98115

Association for Retarded Citizens
(ARC)
National Headquarters
2501 Avenue J.
Arlington, TX 76006

Center on Human Policy
Syracuse University
Syracuse, N.Y. 13244

Especially Grandparents
King County ARC
2230 Eighth Avenue
Seattle, WA 98121

National Association of Development Disabilities
Councils (NADDC)
1234 Massachusetts Avenue NW
Washington, DC 20005
(202) 347-1234

National Council on Independent Living
c/o Access Living of Metro Chicago
815 W. Van Buren Street, Suite #525
Chicago, IL 60607
(312) 226-5900
President: Marca Bristo

National Down Syndrome Congress
1800 Dempster Street
Park Ridge, IL 60068-1146
(312) 823-7550
1-800-232-6373

National Information Center for Children
and Youth with Handicaps (NICHCY)
P.O. Box 1492
Washington, DC 20013
(703) 893-6061
To leave a message: 1-800-999-5599

National Parent CHAIN:
Coalition of Handicapped
Americans Information Network
515 West Giles Lane
Peoria, IL 61614

Parent Advocacy Coalition for Education Rights
(PACER)
4826 Chicago Avenue, South
Minneapolis, MN 55417-1055
(612) 827-2966
(1-800) 54-PACER (MN)
Directors: Marge Goldberg & Paula Goldberg

Parentele: An Alliance of Parents and Friends Networking
for Those with Special Needs
311 South Jersey Street
Denver, Colorado 80224

Parents Advocating Vocational Education
(PAVE)
6316 South 12th Street
Tacoma, WA 98645
(206) 565-2266
(1-800) 5-PARENT (WA)
Director: Martha Gentilli

People First
(503) 378-5794
Salem, Oregon
Contact: Dennis Heath

Siblings for Signifcant Change
105 East 22nd Street
New York, NY 10017
(212)420-0430

Technical Assistance for Parent Programs (TAPP)
312 Stuart Street, 2nd Floor
Boston, MA 02166
(617) 482-2915
Director: Martha Ziegler

The Sibling Information Network
249 Glenbrook Road, Box U-64
Department of Education Psychology
The University of Connecticut
Storrs, CT 06268

United Cerebral Palsy
(UCP)
1522 K Street, NW, Suite 1112
Washington, D.C. 20005
(202) 842-1266

This list was derived from the
Regular Lives Video Manual
distributed by:
WETA
Educational Activities
P.O. Box 2626
Washington, D.C. 20077

Appendix B - List of Citations for Major Court Orders and Consent Decrees

COURT ORDERS

Alabama-
Wyatt v. Stickney, 344 F.Supp. 387 (M.D. Ala. 1973), aff'd sub nom. Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

Kentucky-
Kentucky Association for Retarded Citizens v. Conn., 510 F.Supp. 1233 (W.D. KY. 1980), aff'd, 674 F.2d 582 (6th Cir. 1982), cert. denied, 459 U.S. 1041 (1983).

Louisiana-
Gary W. v. Louisiana, 437 F.Supp. 1209 (E.D. La. 1976).

Minnesota-
Welsch v. Likens, 373 F.Supp. 487 (D. Minn. 1974), aff'd, 550 F.2d 1122 (8th Cir. 1977).

Nebraska-
Horacek v. Exon, 357 F.Supp. 71 (D. Neb. 1973).

New Hampshire-
Garrity v. Gallen, 522 F.Supp.171, 239 (D. N.H. 1981).

North Dakota-
Association for Retarded Citizens of North Dakota v. Olson, 561 F.Supp. 473 (D. N. Dak. 1982), aff'd, 713 F.2d 1391 (8th Cir. 1983).

Oklahoma-
Homeward Bound v. The Hissom Memorial Center, (issued by District Judge James O. Ellison), July 24, 1987.

Pennsylvania-
Halderman v. Pennhurst State School & Hosp., 446 F.Supp. 1295 (E.D. Pa. 1976), aff'd, 612 F.2d 84 (3d Cir. 1979), rev'd, 451 U.S. 1 (1981), reaff'd on remand, 673 F.2d 647 (3d Cir. 1982), rev'd & remanded, 104 S.Ct. 900 (1984), consent decree entered, 610 F.Supp. 1221 (E.D. Pa. April 5, 1985).

West Virginia-
Medley v. Ginsberg, 492 F.Supp. 1294 (S.D. W.Va 19800.

DECREES

Connecticut-
Connecticut Association for Retarded Citizens v. Mansfield Training School, Civ. No. H-78-653 (D. Conn. May 25, 1983).

Florida-
Florida Association for Retarded Citizens v. Graham, No. 79-418-Orl.-Civ. (M.D. Fla. Apr. 26, 1985).

Maine-
Wuori v. Concannon, Civ. No. H-75-80-P (D.Maine, Jan. 14, 1981).

Michigan-
Michigan Association for Retarded Citizens v. Smith, 475 F.Supp. 990 (E.D. Mich. 1979).

New York-
New York State Association for Retarded Children Inc.v. Carey, 596 F.2d 27, 31 (2d Cir.), cert. denied, 444 U.S. 836, 100 S.Ct. 70, 62, L.Ed.2d 46 (1979),727 F. 2d. 240,(1984). consent decree entered on April 30, 1975.

Rhode Island-
Iasimore v. Garrahy, No. 77-727 (D.R.I. 1982).

Texas-
Lelsz v. Kavanagh, 98 F.R.D. 11 (E.D. Tex. 1982), appeal dismissed, 710 F.2d 1040 (5th Cir. 1983), consent decree entered, Civ. No. S-74-95-CA (E.D. Tex. June 5, 1985).

Vermont-
In re Robert Brace, Nos. 27, 28, 44, 17, 13, 47 (Vt. Dt. Ct., Unit No. 1, Brandon Cir, Oct. 16, 1980).

Washington D.C.-
Evans v. Washington, 459 F.Supp. 483 (D.D.C. 1978).
Evans v. Barry, Civ. Action No. 76-1293 (D.D.C. supplemental consent ordered entered, Feb. 13, 1983).

This list was derived from a mimeograph received from Judith Gran, Public Interest Law Center of Philadelphia - PILCOP, dated September 11, 1987.

FOOTNOTES

1 Best-Sigford, B., Bruininks, R., Lakin, K.,& Hill, B., (1982)."Resident Release Patterns in a National Sample of Public Residential Facilities," American Journal on Mental Deficiency, Vol. 87 No. 2, p. 130.

2 Braddock, D., Hemp, R., & Fujiura, G., (1987)."National Study of Public Spending for Mental Retardation and Developmental Disabilities," American Journal on Mental Deficiency, Vol. 92 No.2 , p.125.

3 Information received in a letter from L. VanDesande, Michigan Department of Mental Health, Office of Public Information, Lansing, MI, December 3, 1986.

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8 Ibid, p. 81.

9 Heal, L., Haney J., & Novak Amado, A., (1988). Integration of Developmentally Disabled Individuals into the Community. Baltimore: Paul H. Brooks Publishing Co., p. 58.

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Marsh, (April 1989).

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Trainor, C., & Miller, T. (1982). Resource Guide on Community Placement for Persons With Mental Retardation. Oakland County, Michigan: Association for Retarded Citizens - Oakland County in Collaboration with Awareness Communication Team for Developmentally Disabled, pp. 15-16.

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423 Mich 466.

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Bates, M. (1987)."State Zoning Legislation: a Purview," Wisconsin Council on Developmental Disabilities, p.44.

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Ibid.

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Ibid, Appendix.

31
Michigan Compiled Laws Annotated, p. 337.

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Heal et al., (1988), p. 278.

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Ludlow, B., Ed., (1989). "In the Courts: Cleburne Conclusion," News & Notes - A Quarterly Newsletter of the American Association on Mental Retardation, Vol. 2 No. 1, p.1.

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National Mental Health Association (1988)."Your Rights to Housing a Consumer's Guide to the Fair Housing Act of 1988," Alexandria, VA. (Mimeographed)

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41 Lakin et al, (1985). p. 3.

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Braddock et al., (1986), Table 2.

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95 Johnson, A., Johnson, M. & Buse, R., (1987). Egonometrics: Basic and Applied. New York, New York: Macmillan Publishing Company, p. 431.

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97 Hudson, p.7.

98 Braddock et al., (1986) pp. 285-296.

99 Ibid, Table 2.

100 Braddock et al., (1986) p. 296.

101 Telephone interview with Joe Frick, Financial Reporting Section, Office of Accounting, Michigan Department of Management and Budget, Lansing, Michigan, March 20, 1989.

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